PARTICIPATORY APPROACHES IN HEALTH PROMOTION AND HEALTH PLANNING
A LITERATURE REVIEW

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The views expressed in this publication are those of the authors and not necessarily those of the Health Development Agency.
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FOREWORD

The research described in this document was originally commissioned by the Health Education Authority (HEA) as part of its Forward Research Programme which began in 1996.

Other projects from the programme included studies examining health inequalities, social capital, community participation and the evaluation of social action programmes. There was also a focus on particular population groups such as black and minority ethnic communities and older people. By 31 March 2000, the findings from much of this work had already been published. However, a number of important studies were still outstanding.

On 1 April 2000 the Health Development Agency (HDA) was established, in accordance with the government white paper Saving Lives: Our Healthier Nation, following the demise of the HEA.

The HDA is a special health authority with a remit to improve the health of people in England in particular, to reduce inequalities in health between those who are well off and those on low incomes or reliant on state benefits. It achieves this by:

- working with key statutory and non-statutory organisations at national, regional and local level
- finding out what works and maintaining this evidence base
- turning the evidence into action by building up the skills and capacity of those working to improve the public’s health
- advising on the setting of standards for public health planning and practice.

In keeping with its remit, the HDA aims to publish the outstanding reports from the Forward Programme and to continue to disseminate the findings from these and other studies as widely as possible.

The results from this report: Participatory approaches in health promotion and health planning a literature review clearly have value to the public health field and will help inform the work of all those working in this priority area.

This literature review was commissioned as a result of HEA expert consultations on health promotion with vulnerable groups. The review provides a critical rather than a comprehensive review of the literature. It discusses definitions and theoretical
constructs and provides useful information on applications, methods and tools, examples of application from case studies, and finally assesses the contributions and challenges of participatory approaches.

This timely review which makes a useful contribution to the growing interest in participatory approaches in health promotion and planning and will help to inform the work of those involved in community participation for health improvement.

Hilary Whent, Dominic McVey, Lorraine Taylor

*Health Development Agency*
EXECUTIVE SUMMARY

There has been an increasing interest, particularly in the last two decades, in both the theoretical and practical aspects of participatory approaches. Much of the interest has been generated by the expected value of these approaches in dealing with problems of social deprivation and poverty alleviation. The approaches also have been boosted by interest in the processes of democratisation and good governance in a rapidly changing world.

The roots of participatory approaches can be found in the area of social development, which includes health and social welfare. Based on experiences of the industrial countries in community development and community organisation, planners and former colonial administrators sought to create community development programmes in the newly created nations. In several of these countries, departments of community development were created to address the social and welfare needs mainly of the rural poor.

By the 1960s, however, it was clear that many of the assumptions on which the community development approach, in both the industrial and developing countries had been based, were not true. Thus, in the late 1960s and 1970s, interest in participation revolved around the more theoretical and ideological aspects of this approach by trying to understand the nature of the environment and socioeconomic-political structures which were responsible for poverty. Examinations about the role of the 'people', particularly in terms of power and control over their own lives, became a paramount concern. Theoretical constructs developed around the concepts of 'people's participation' and 'empowerment'. They addressed issues of oppressive structures as well as the need to provide the socially-excluded and marginalised people with opportunities, through education and confidence building, to gain the means by which to change these structures. These constructs highlighted three key questions concerning community participation: 1. Who defines the community? 2. Is participation a means or end? 3. Who decides on priorities and action – professionals or beneficiaries?

By the 1980s, interest had shifted from theory into practice and much of the literature concentrated on methods, tools and techniques on how to initiate and sustain participation. Efforts were now focused on providing opportunities for all community members, not just those in the formal structures, to be able to have
confidence and power to enter the decision-making process. Based primarily on qualitative research methods, these tools and techniques began to focus on rapid appraisals and participatory action research, two areas, which have gained increasing support in the last few years. Robert Chambers (1995) and his colleagues have argued convincingly for the promotion of the rapid appraisal approach in its modified form of participatory appraisals/participatory learning methods. The Canadian government, beginning with its support for the Council for Adult Education and, most recently, in the commissioning of guidelines for participatory action research, has supported work in this area.

A review of the literature on social exclusion argues that it is possible for participatory approaches to address issues in this context. Participatory approaches are not a panacea but rather a group of approaches among many. Also, it remains unclear whether such approaches achieve in engaging the support of and empowering the most poor and socially marginalized. It could be argued that they are necessary but not sufficient to address these issues.

A review of participatory approaches in the health field using these methods and tools shows a range of experiences on a continuum devised by Hart and Bond (1995) from experimental, where the process is defined and controlled by outside professionals, to empowering, where beneficiaries are provided with opportunities and experiences to manage the process.

The review of the literature suggests several conclusions critical to assessing potentials and challenges for participatory approaches. Firstly, the literature clearly shows that the historical development of participatory approaches has been flexible, accommodating, creative and exploratory. Thus, to date, it is not possible to give a universal definition to either 'community' or 'participation'. What is clear is that the terms and their development, in both theory and practice, depend on the environment in which they exist. The model for participatory approaches is still ephemeral and often rhetorical.

Secondly, focusing on health concerns but not confined to it, the literature shows a tension as to whether community participation is to be seen as specific intervention (package, product) for health improvement or a process of change. Writings looking at community participation as a product with a defined outcome have recorded the difficulties with this perception specifically in the light of the expectations. Community participation is better understood and expectations are more realistic if it is seen as a process.

Thirdly, the literature, particularly the case studies, emphasises the need for participatory approaches to deal with the question of power and control. Although authors have argued that community participation in health is not about political participation, the literature suggests, in practice, that it is a main issue. Those who promote empowerment constantly confront the question of whether the less
powerful can be empowered or whether they only gain power through asserting themselves, usually in conflict situations. The literature shows that any discussion about participation is in some way a discussion about power and control.

In the context of developing a strategy for research based on participatory approaches the following considerations are important. Any project must have proper preparation, which would include seeking a conducive environment for such research, developing rapport with community people and ensuring the continuity of an appraisal exercise. Secondly, the research design must be flexible and iterative, use the right methods for the research question and provide the necessary training to all those involved in the project. Thirdly, issues of power and control must be made transparent in areas including the use and ownership of information, the role of professionals and lay people and the recognition and management of conflict.

References


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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immuno-deficiency syndrome</td>
<td>PPP</td>
<td>people’s participatory planning process</td>
</tr>
<tr>
<td>CCDB</td>
<td>Christian Commission for Development in Bangladesh</td>
<td>PR</td>
<td>participatory research</td>
</tr>
<tr>
<td>CHW</td>
<td>community health worker</td>
<td>PRA</td>
<td>participatory rural/rapid appraisal</td>
</tr>
<tr>
<td>CP</td>
<td>community participation</td>
<td>RA</td>
<td>rapid appraisals</td>
</tr>
<tr>
<td>CRAR</td>
<td>community reflective action research</td>
<td>RAP</td>
<td>rapid assessment procedures</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
<td>REA</td>
<td>rapid epidemiological/ethnographic assessment</td>
</tr>
<tr>
<td>HEA</td>
<td>Health Education Authority</td>
<td>RPA</td>
<td>rapid participatory appraisal</td>
</tr>
<tr>
<td>HIV</td>
<td>human immuno-deficiency virus</td>
<td>RRA</td>
<td>rapid rural appraisal</td>
</tr>
<tr>
<td>HFA</td>
<td>Health for All</td>
<td>SARTHI</td>
<td>Social Action for Rural and Tribal Inhabitants</td>
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<tr>
<td>MCH</td>
<td>mother and child health</td>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>NA</td>
<td>needs assessment</td>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>NGO</td>
<td>non-governmental organisation</td>
<td>UNRISD</td>
<td>United Nations Institute for Social Development</td>
</tr>
<tr>
<td>PALM</td>
<td>participatory action learning methods</td>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>PAR</td>
<td>participatory action research</td>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>PET</td>
<td>participatory education theatre</td>
<td>VIPP</td>
<td>visualisations in participatory programmes</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>PLA</td>
<td>participatory learning approaches</td>
<td>ZOPP</td>
<td>goal-oriented project planning</td>
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CRAR  Community reflective action research: a combination of community collaboration and participatory research that was developed in Canada. It is intended to improve the practice of health promoters and to create community control of education and action.

PAR  Participatory action research (also sometimes called action research): based on theoretical constructs of people's participation stemming from the work of Lewin (see 'Action research' in Chapter 3).

PLA  Participatory learning approaches: the latest term used to describe the participatory methods originally developed within RRA and then PRA. It reflects the shift in interests to include urban as well as rural contexts and also in the long-term capacity-building process rather than rapid data collection exercises.

PR  Participatory research: an alternative term for PAR (see above).

PRA  Participatory rural appraisal or participatory rapid appraisal: as RRA developed and expanded beyond its original rural data-gathering objectives, the participatory methods employed were renamed participatory rural/rapid appraisal to reflect their potential as the instigators of a learning process. The term PRA has subsequently been replaced with the term PLA (see above).

RA  Rapid assessments and rapid appraisals: both became popular in the health and development fields in the early 1980s, although the two are different. Include rapid epidemiological and ethnographic assessments and rapid assessment procedures. These are primarily means of obtaining quality information quickly to implement programmes. Rapid ethnographic assessments and rapid assessment procedures are both based on methods drawn from social anthropology. The methods of rapid appraisals were originally drawn from rural development, in particular agricultural projects, and were integrated under the rubric of rapid rural appraisal (see below).
RAP Rapid assessment procedures: these fall within the category of rapid assessments (see above) and employ methods drawn from social anthropology in the field of health and nutrition to gain insight into people’s beliefs and actions for health care. A number of RAP manuals have been produced for specific applications.

REA Rapid epidemiological assessment or rapid ethnographic assessment. See RA above.

RPA Rapid participatory appraisal: developed using the RRA framework in the 1980s specifically for health programmes and involves community members in the appraisal process; they are engaged in data analysis and priority setting and not just as a source of information.

RRA Rapid rural appraisal: this term covers a range of methods for rapid appraisals mainly developed from agricultural projects. RRA differs from rapid assessments in that the focus is not solely on the rapid collection of data, but also on community participation and an intersectoral approach. Chambers has been very influential in developing this area (see ‘Empowerment’ in Chapter 3). RRA has developed into PRA (see above).

VIPP Visualisations in participatory programmes: an approach to project planning, which uses visualisation tools to promote participation and empowerment. It draws on the work of Freire and others in the field of participatory action research.
1. INTRODUCTION

Background

At the request of the former Health Education Authority (HEA), this literature review was undertaken as part of the HEA's Research Strategy. The strategy has identified tackling health inequalities as a key priority. Thus, it is recognised that health promotion approaches must expand beyond addressing only the health behaviour of the individual.

In recent years there has been increasing interest in participatory approaches, which have been developed to improve the health of communities. Community participation (or involvement as the World Health Organization (WHO) prefers to call it) has been identified as one main principle of primary health care (PHC) as well as a principle of health promotion as articulated in the Agenda 21 emerging from the Rio Conference. In addition, there is evidence that efforts which involve beneficiaries at the beginning of programmes are more effective than those which do not (Gillies, 1997; Chambers, 1997). Experiences in a range of countries throughout the world have shown the potential of participatory approaches as a means of obtaining programme objectives, as a research strategy and as an educational process for both professionals and people in the community.

The purpose of this literature review is to contribute to the above research strategy. To do so, it identifies and describes the major themes and issues, which are presently shaping participatory approaches in the field of health. The overall objective is to provide information, which can be useful in identifying ways to address health inequalities, for example building social capital and social action projects.
The context

In order to achieve the overall objective of this report, it is useful to review the context within which it was commissioned. Health inequalities have been a concern to all British governments since 1945, however, the significance attached to health inequalities has varied with differing governments. This concern has been based on a large amount of evidence accumulated over a period of many years (Acheson, Department of Health, 1998a; Townsend and Davidson, *The Black Report*, 1982).

Health is unevenly distributed both between and within societies. There are differences between and within countries in terms of the expected life expectancies of men and women and the mortality and morbidity rates (Table 1).

Table 1. Estimates of crude death rate, infant mortality rate, and expectation of life at birth for selected countries (data from UN 1981)

<table>
<thead>
<tr>
<th>Country</th>
<th>Crude death rate (per 1000 per year)</th>
<th>Infant mortality rate (per 1000 live births)</th>
<th>Life expectancy at birth (per 1000 live births, males)</th>
<th>Life expectancy at birth (per 1000 live births, females)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt</td>
<td>10</td>
<td>110</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>Malawi</td>
<td>25</td>
<td>130</td>
<td>41</td>
<td>44</td>
</tr>
<tr>
<td>Brazil</td>
<td>9</td>
<td>82</td>
<td>58</td>
<td>61</td>
</tr>
<tr>
<td>USA</td>
<td>9</td>
<td>12</td>
<td>70</td>
<td>78</td>
</tr>
<tr>
<td>China</td>
<td>7</td>
<td>49</td>
<td>66</td>
<td>69</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>6</td>
<td>37</td>
<td>65</td>
<td>67</td>
</tr>
<tr>
<td>Sweden</td>
<td>11</td>
<td>7</td>
<td>72</td>
<td>78</td>
</tr>
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</table>

From *The Health of Nations* (1985, p 5)

There is considerable evidence that these health inequalities are linked not only to the differentials in wealth between these countries but also to the distribution of income and resources within these societies (Wilkinson, 1996).

There is a great deal of evidence concerning the health inequalities, which exist in England. The evidence has been collected regularly over the years (Macintyre, 1986; Townsend and Davidson, 1982; Townsend and Davidson, 1990). It shows that within England there are differences in mortality within the population which are related to socioeconomic position (whether measured by social class, by type of housing tenure, by a deprivation index), the region people live in, their ethnicity, their gender and their age. The nation's health has improved since the end of the Second World War in terms of an increased average life expectancy and a decline in infant, child and mortality rates at the national level. For example, whereas in 1960 infant mortality per 1000 live births was 21.8, in 1975 it was 14.2 Similarly, the life expectancy of the population as a whole has improved during this century (Table 2).
Table 2. Increases in life expectancy in England and Wales each decade 1901–91 (additional years of expectancy at birth)

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</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>4.1</td>
<td>6.6</td>
<td>2.3</td>
<td>4.2</td>
<td>2.3</td>
<td>6.5</td>
<td>2.4</td>
<td>0.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Women</td>
<td>4.0</td>
<td>6.5</td>
<td>2.4</td>
<td>4.5</td>
<td>2.4</td>
<td>7.0</td>
<td>3.2</td>
<td>1.2</td>
<td>1.8</td>
</tr>
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Despite this overall improvement in health status, the disparities between different groups within the population have grown. There are increasing differentials in terms of mortality. The most common way of looking at these gaps over time is to look at the mortality rates by social class as defined by the Registrar General. Figure 1 shows life expectancy at birth and Figure 2 shows infant mortality disaggregated by social class.

Fig. 1. Life expectancy at birth by social class (1987–91)
Fig. 2. Infant mortality rates by father's social class – England and Wales, 1993–95

Source: Drever and Whitehead (1997)

Other direct measures of socioeconomic (SES) status such as housing tenure or employment status also show similar inequalities in health in terms of not only premature death but also more experience of illness. These data are well known and are not disputed. What these figures mean has been summarised more dramatically by the following illustrations set out by Benzeval, Judge and Whitehead (1995, p. 4), but derived from others.

Table 3. Illustrations of inequalities in morbidity and mortality

- The total excess deaths in the most disadvantaged half of the population is equivalent to a major air crash or shipwreck every day (Jacobson, Smith and Whitehead, 1991)

- There would be 42,000 fewer deaths each year for people aged 16–74, if the death rate of people with manual jobs were the same as for those in non-manual occupations (Jacobson, Smith and Whitehead, 1991)

- A child from an unskilled social class is twice as likely to die before the age of 15 as a child with a professional father (Woodroffe et al., 1993)

- Socioeconomic gradients exist for most common causes of long-standing illness and disability – musculoskeletal, heart and circulatory and respiratory conditions – with the highest rates occurring among people in manual occupations (Breeze, Trevor and Wilmot, 1991)

Source: Jacobson, Smith and Whitehead (1991, p. 4)
Explanations for health inequalities

There has been a variety of explanations given to explain these persisting health inequalities. Four main explanations were propounded by the authors of the Black Report (Townsend and Davidson, 1982). These were the artefact, the social selection, the behavioural and the materialist explanations. These have been subsequently reviewed (Vagcro, 1995).

The artefact explanation proposes that the gap in mortality rates between different social classes is a consequence of the statistical construction of who belongs to which social class (Illsley, 1986). For example, there may be fewer and fewer people working in manual unskilled work owing to there being less of this type of work today when technology is a component in so much employment. This would mean that although the health of people in class V is worse, it may involve fewer people than formerly. Social class obscures women, for it is based on the employment of husbands and fathers. Nevertheless, other measures of socioeconomic status such as housing tenure or car ownership have come up with similar differences. This type of explanation is not given a great deal of credibility in explaining health inequalities although work is continuing to develop better measurements of socioeconomic status and health.

The social selection explanation postulates that the social mobility of the healthy is upward and that those with poor health (chronic illness, disabilities) tend to have downward mobility. Work by Baird in Aberdeen (Baird, 1974) has drawn attention to the way in which mothers who themselves were of low birthweight may also give birth to low birthweight babies and that taller women tend to be more socially mobile when they marry than shorter women (Illsley, 1955). It has been generally considered that social selection can account for only a small proportion of the patterns of health inequalities and that it is difficult to disentangle the physical aspects from their social context and consequences. However, recent work on life course analysis which links childhood data with morbidity and mortality in adult life seems to suggest that health in early life is connected to outcomes in later life (Barker, 1990) and this explanation is coming under renewed discussion and scrutiny. Life course analysis is needed in order to take into account the complex ways in which biological risk interacts with economic, social and psychological factors in the development of chronic disease (Bartley, Blane and Montgomery, 1997).

The behavioural explanation argues that individuals in poor socioeconomic circumstances tend to take up health-damaging behaviours such as smoking, risk-taking behaviour that results in accidents, or poor nutrition. There is considerable evidence that there are higher rates of all these patterns of behaviour in lower SES groups. Policy interventions which emphasise individual responsibility for health such as the Health of the Nation targets to reduce smoking and accident rates by the year 2000 emphasise the impact of lifestyles and health as the responsibility of the individual. However, in general, research seems to indicate that it is difficult to
separate individual behaviour from the social, physical and economic environment in which people live and that the behaviour of individuals is embedded in, and constrained by, their social environment. Graham's work (1993) on smoking is an example of this approach which combines the materialist and behavioural approaches and others also concur in this approach (Blane, 1985, Macintyre, 1986). For example, childhood accidents are more frequent amongst children in social classes IV and V and yet this does not imply necessarily that parenting is less adequate, for these children have less safe play areas and their homes may be heated with gas and electric bar fires.

Materialist/structuralist explanations argue that there is an association between high levels of mortality and morbidity and poor material circumstances. The use of small area statistics from the census at a ward level (Thunhurst, 1985) and the development of deprivation indices (Jarman, 1983) have enabled research to explore links between the ecological environment (physical and socioeconomic circumstances) and health outcomes. Townsend, working with a number of others, has shown that poor health is positively correlated with measures of deprivation used on an electoral ward level in different cities in England. The proportion of people having their electricity cut off, not owning cars, not owning houses, living in overcrowded homes, having free school meals for their children and being unemployed is strongly correlated to low birthweight, standardised mortality rates, and levels of permanent sickness (Townsend and Davidson, 1982, Townsend and Davidson, and Whitehead, 1990). The ‘Black Report’ and the ‘Health Divide’ favoured the materialist/structural explanation as having the most explanatory power in unravelling the reasons for the persisting health inequalities within England.

There is increasing recognition that the reasons for health inequalities are complex and include a combination of material socioeconomic circumstances and the individual’s psychosocial environment. But there has been recent attention given to people’s social circumstances and to the notion of social capital. This is a phrase used by Putnam (1995) and Wilkinson (1996). Putnam says:

By ‘social capital’ I mean features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives . . . To the extent that the norms, networks and trust link substantial sectors of the community and span underlying social cleavages – to the extent that the social capital is of a bridging sort – then the enhanced co-operation is likely to serve broader interests and to be widely welcomed. (Putnam, 1995, quoted in Wilkinson, 1996)

The approach of developing social capital is one which stresses social cohesion to combat the effects of poverty and social exclusion. It is based on an understanding that the effects of social exclusion are economic, psychological and social. In Europe, social exclusion is the term used in preference to poverty or deprivation, for it is more all-embracing of the multiple consequences of relative poverty.
These different explanations of health inequalities, often referred to as the causal debate, are important in terms of understanding the thinking behind policy and interventions concerning combating health inequalities. Different types of policies and interventions reflect different explanations of health inequalities.

Participatory approaches are of more relevance to the materialist/structuralist explanations than the behavioural, artefact or social selection explanations and are important in interventions on the social level rather than the individual level.

**History of health policies in the United Kingdom**

Although in the past a number of different national and local policy interventions have been used to combat health inequalities, contemporary policy makers face the problem of the lack of a previous focus on interventions to inform health policy and planning. The subject is sensitive and political because it connects with central issues concerning the distribution of wealth within a country and with ideas of social wellbeing. That health inequalities exist is beyond dispute. They have been documented in the Black Report (Townsend and Davidson, 1982) commissioned by Labour, the Health Divide (Whitehead, 1987) commissioned by the Conservative government and most recently the Acheson Report (Department of Health, 1998a). They all show that whereas in general, health outcomes may be improving the gaps between classes I and II, and IV and V are increasing.

In recent times, at the policy level, the Conservative government in the 1990s launched the Health of the Nation policy in a White Paper of that title (Department of Health, 1993) with targets for decreasing premature deaths caused by coronary heart disease, mental health problems, accidents and cancers, and sexual health problems. This policy focused on variations and differentials in health which lead to premature death and targeted interventions in the above key areas. The approach was mainly conceived as encouraging individuals to take responsibility for their health which was related to the behavioural explanation of health inequalities.

The Labour government produced a Green Paper *Our Healthier Nation: a Contract for Health* (Department of Health, 1998b) which prioritised combating health inequalities. The strategy targeted similar areas of health to the Health of the Nation policy – heart disease and strokes, accidents, cancer and mental health – but focused on developing partnerships between the government, local communities and individuals.

In late 1998, the Acheson Report was published. This informed the consultation process and the final White Paper *Saving lives – our healthier nation* (Department of Health, 1999). Alongside this, the Government also produced *Reducing health*
inequalities — an action report (Department of Health, 1999). The Acheson Report marked a significant shift in policy and rhetoric and set out a radically different health policy agenda from the previous Conservative government. Part 1 of the Acheson Report provided a concise review of current evidence of health inequalities, and Part 2 presented recommendations to combat these inequalities embedded in current research evidence. The report adopted the socioeconomic model of health and health inequalities. This model included structural and material factors as explanations of health differentials in addition to behavioural factors. In addition, the report highlighted the need to take a multisectoral approach to health improvements, addressing health problems in the context of not only medical services but also in the context of the existing socio-political-economic environment. The recommendations of the report reflect its conclusion that poverty is a principle cause of ill health. Changes in the taxation system, in employment policy, in education, in housing, in nutrition and in health service delivery are all addressed.

These policies have renewed the interest in and emphasis on community roles in health improvements. For example, reviews of past experiences suggest that individually focused interventions can achieve ‘modest’ results in encouraging health-related behaviour change. Such approaches, however, are least successful with those who are least well off. This evidence suggests that there is a clear need to move beyond the focus on changing the behaviour of individuals to encompass wider social networks, support and community resources. A number of reviews reinforce the potential of ‘strengthening communities’, that is the social environment as a critical element of health programmes. This is the practical implication of the concept of social capital (Gillies, 1997).

Work has also been undertaken to begin to identify characteristics of successful approaches to address the problem of inequalities (Gillies, 1997; Centre for Reviews and Dissemination, 1997). A summary of these findings is given in Table 4.

It is clear that the present policy environment has renewed a connection between the Department of Health and local communities. In the United Kingdom, many of the experiences in community participation have grown out of the community development context and not in the health context. A more detailed discussion can be found in Chapter 3. The link between community participation and health on the global level was crystallised in the Alma Ata Declaration on Primary Health Care (World Health Organization, 1978) which placed community development in the context of health improvements not health in the context of community development. The analysis and experiences which have come out of this framework open new opportunities to address the issues of health inequalities. The global experiences that led to and continued from the Alma Ata Declaration have new relevance in the United Kingdom now.
Table 4. Characteristics of successful approaches that address inequalities

- Local assessment of needs, especially involving local people in the research process itself
- Mechanisms that enable organisations to work together – ensuring dialogue, contact, and commitment
- Representation of local people within planning and management arrangements (the greater the level of involvement the larger the impact). For example, local committees are vital to support the sharing of power and responsibility for change, and allow local people to voice approval or dissent
- Design of specific initiatives ('interventions') with target groups to ensure that they are acceptable, culturally and educationally appropriate, and working through settings that are accessible and appropriate to them
- Training and support for volunteers, peer educators and local networks (ensures maximum benefit from community-based activities)
- Political visibility of support and commitment
- Reorientation of resource allocation to enable systematic investment for community-based programmes
- Policy development and implementation that brings about wider changes in organisational priorities and policies, driven by community-based approaches.
- Increased flexibility of organisations that supports increased delegation and a more responsive approach

Scope of review and methodology

Given both its purpose and the resources allocated to it this review is a critical rather than a comprehensive one. In other words, the literature reviewed is firstly, mostly published literature (with the exception of the literature in the UK which we address in 'Examples of empowering action research' in Chapter 5) and secondly, the literature which has relevance to planning and implementing a social action project. The literature is from both the industrial and the so-called 'developing countries' where many of these approaches were pioneered.

One further note about the literature is important. Much of the writing on the UK experiences is in the community development context not the health sector. In addition, much of it has not been published. It remains in the grey literature. This review focuses on the rhetoric of community participation and how this translates into actual practice. This literature addresses the role of community participation in the formal and informal health sector. Complementary work on mapping community participation projects in England and the formulation of good practice criteria and a web-accessible database have been developed by the former HEA.

The structure of this review is as follows. In this chapter, the review has been placed in the context of the present discussions in the United Kingdom about health inequalities. In Chapter 2, the definitions concerning community and participation...
are presented. In Chapter 3, the major themes and issues, which have shaped the present participatory approaches in the health field are identified. Chapter 4 then describes applications and the methods and tools on which these applications rely. Case studies are examined in Chapter 5 to illustrate how participatory approaches have been developed before analysing the potential and challenges the approach presents. It makes no attempt to identify every tool and/or method used nor to identify every project in which these approaches have been applied. Chapter 6 assesses the contributions and challenges of participatory approaches to health improvements. Concerning the methodology, the main researcher published two articles in 1996 reviewing the major aspects of participatory approaches (Rifkin, 1996a and 1996b). These reviews have served as the basis of this work. A further literature review was undertaken for the years 1995 to 1997. The dimensions of this literature search are considered in Appendix D. To repeat, the methodology is designed to give a critical rather than comprehensive analysis.

References


2. DEFINITIONS OF COMMUNITY PARTICIPATION

Summary

In this chapter we briefly review the literature on definitions of community participation. We will begin with definitions of community, then community participation and finally identify issues for health planning today. The final section raises questions focusing on the issues addressed in Chapter 3. These questions are: 1. Who defines ‘community’ – community people or outsiders? 2. Is participation a means or an end? 3. Who decides on priorities and action – professionals or community people?

Defining community

For planners engaged in seeking improvements to alleviate poverty in the social sector, and specifically in the health sector, the need to involve the intended beneficiaries of the intervention has long been recognised (Midgley et al., 1986). If the intervention relies on the participation of the beneficiaries in the intervention, then the need is critical. For this reason, the literature in the field shows a great amount of reflection about the definitions of community and community participation. The literature illustrates the divergent views of both the conceptual and practical approach to the definition. For example, in the article by Jewkes and Murcott (1996) they cite an article by Hillery (1955) in which he gives 55 definitions of community. Similarly the definition of participation has a wide range of meaning. The proliferation of meanings in the post-war era, in part, reflects the concerns of social planners with engaging people in the planning and implementing activities for self-improvements (Oakley et al., 1991). The wide range of concepts and experiences in both the Western and non-Western world has so far militated against a universal agreement on the definition of any of these terms.

Jewkes and Murcott (1996) review definitions of community in general and then in the context of their importance to health planners using case studies from England. After presenting the Oxford dictionary’s definition, which sees communities in their
geographic sense, that is people living in the same area, the article proceeds to trace the interest and experiences of social scientists trying to define the term. Rooted in the culture of Europe and the United States, the authors follow definitions emerging from differences in urban and rural communities in the 1870s to the concerns, one hundred years later, with the consequences of community activism.

Concerning the definition of community in the health literature, there is a tendency to define community, firstly, in terms of geography (Agudelo, 1983; Rifkin, Muller and Bichmann, 1988). It might be argued that this characteristic reflects the views of epidemiologists who seek ‘target’ groups within geographical confines on which to focus interventions (Rifkin, Muller and Bichmann, 1988). The Alma Ata Declaration which made community participation a key factor in primary health care and thus, part and parcel of the health policy of all member nations of the World Health Organization does not offer a definition of the term (World Health Organization, 1978). Jewkes and Murcott (1996), however, argue that the definition implicitly implies that a community is a geographically located group of people with shared economic, social-cultural and political interests and shared problems and needs.

Others do not attach a geographic characteristic to the definition. Suliman (1983), for example, sees communities as groups of people with common perceptions of needs and priorities and the capacity to take responsibility to act upon these needs. The Ottawa Charter on Health Promotion goes further and sees communities as sub-units of a country thus implying hierarchical relationships from individual and family to community and country (Ottawa Charter for Health Promotion, 1987). Thus, it bases the definition on social units as well as formal administrative units. The above illustrations support the conclusion of the review of Jewkes and Murcott that ‘there is a singular lack of specificity and agreement about what the “community” whose participation is regarded as so essential actually is’ (Jewkes and Murcott, 1996, p. 558).

Defining community participation

The literature seeking definitions of community participation is equally as vast. In Europe and America in the early twentieth century much of the concern focuses on the rights and duties of citizens to participate in the processes and activities which affect their daily lives. These views emerge from the entire processes of democratisation.

One dimension of this definition related to poverty alleviation took the interpretation out of the wider democratic process and focused it on a variant of liberal democratic theory known as neighbourhood democracy (Midgley et al., 1986). Emerging from work done in the 1970s mainly on poverty in urban areas, this focus was more attractive to sceptics of representative democracy that sought to translate participation into local action and political responsibility on a much smaller scale. It advocated opportunities for those who could find no place in
larger, more representative organisations. This approach allowed for ways to address local issues and build local capacities.

In the 1950s and 1960s contributions from the field of social development, particularly in the context of rural development of so-called developing countries, increased and made this dimension more concrete. They also encompassed the values of self-reliance and sustainability concerns for project planners. Oakley (1989, p. 9), in his book on community involvement for the World Health Organization, quotes the definitions below as typical illustrations:

- Participation means . . . in its broadest sense to sensitize people and thus to increase the receptivity and ability of people to respond to development programmes, as well as to encourage local initiatives.

- With regard to development . . . participation includes people's involvement in decision-making processes, in implementing programmes . . . their sharing in the benefits of development programmes and their involvement in efforts to evaluate such programmes.

- Participation involves . . . organized efforts to increase control over resources and regulative institutions in given social situations on the part of groups or movements of those hitherto excluded from such control.

From a review of the subject in the context of social development with a focus on poverty, Oakley (1989) identifies three types of participation. The first is *marginal participation* in which participation is limited in scope and focused on a particular objective. Oakley notes this type has little influence on the development process. The second is *substantive participation* where beneficiaries have some input determining priorities and contributing to activities and receive benefits but have no role in decision-making. The scope of participation is externally controlled. The third is *structural participation* in which the people play an active and direct role in project development. As implied by its designation, there is a shift in power and decision-making which allows a greater role for the community with support of external people. This concept is further refined by Muller (1983) who makes a distinction between *direct participation* and *social participation*. The former he defines as implementation of projects through the mobilisation of community resources. The latter is the situation where the community decides and therefore takes control over the factors that control health.

These definitions highlight characteristics of participation which are equally useful to health planning in relation to communities in both the industrial and non-industrial world.

Discussions about participation in health care crystallised in acceptance of primary health care in 1978 by the member nations of the World Health Organization (WHO, 1978). Primary health was defined as:
... essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every state of their development in the spirit of self-reliance and self-determination.

This definition reflects the view that health is not merely a delivery of services but a reflection of the socio-political-economic environment. It is also a responsibility of individuals and communities not solely of health professionals.

The discussion of community participation in health in the UK has taken a somewhat different line. Primary health care here is almost exclusively seen as a delivery of services at the first line of contact. Ong (1993) describes this view, updating it in the current context of UK health policy. She points to the policy framework of the Department of Health published in 1992 which addresses participation in health specifically in terms using the health services. This report interprets the user of health services as the consumer, a view she suggests taken directly from the business world. She counterposes this interpretation with the view of the user as participant. She notes that in these different points of departure, the former sees the user as an individual who wants a service to change in structure and/or character to meet that individual need. The latter sees the user as a social being who has a totality of needs of which health is only one. The choice of definitions has implications for health managers in the decentralisation of health services. Ong argues that in order to ensure health services are available to those most in need, the beneficiaries must be involved in the development of these services as participants not merely as service users. If not, the services are underutilised. Demand for services is generated by user perceptions of whether services meet their needs not the needs of the health professional.

One specific aspect of the argument that Ong puts forward is that health must be seen in the context of equity and thus, managers must look at the definition of health that has been debated in the more recent literature and is therefore worth mentioning. This aspect is the WHO argument to replace the term 'community participation' with 'community involvement'. WHO argues that the latter terminology has the implication of a deeper and more personal attachment of community members to primary health care (Oakley, 1989). In reality, the literature reflects that the term is used interchangeably except in WHO documents. It also reflects a continued lack of universal definition for its usage.

Critical questions

Although the definitions of both community and participation discussed above are fairly wide and flexible, they do raise some critical questions for planners, which must be addressed. In this section we identify these questions. In Chapter 3, they
are addressed in some detail. While experience suggests that universal answers to these questions are neither realistic nor necessary, experience also suggests that unless those involved in a specific programme are transparent about the answers, hidden contradictions and expectations will increasingly place limits to the progress of the programme. These questions are:

1. **Who defines community – community members or outsiders?** The literature continues to show that most definitions are created by those who are the programme planners. The consequences are that the perceptions of what is a community are the views of the outsider rather than of beneficiaries of the programme. The study of Jewkes and Murcott (1996) describes differences in views of these two groups and illustrates how assumptions held by outside planners are unfounded. They conclude that differences in definitions and assumptions must be recognised as they lead to some fundamental rethinking about community participation in health.

2. **Is participation a means or an end?** Oakley (1989) explores this question. He suggests that in the field of rural development (but equally so in health) participation has often been used to mobilise people to attain targets defined by outside planners. As a result, beneficiaries mainly contribute in ways defined by others than themselves. This problem then raises two further questions. Firstly, is participation active or passive? The issue here is whether agreement of community members to proposals from professionals or other outsiders can be considered participation. Many would argue it is not, because for actions to be deemed participation they need to have the active involvement of individuals and lead to their empowerment (Nelson and Wright, 1995). The second is whether community participation is a product or a process. If it is a product then it is translated in terms of outcome or impact and often measured in terms of concrete results (Agudelo, 1983; Palmer and Anderson, 1986). Others would argue it is a process whereby there is a qualitative change and improvements are a result of a combination of factors from learning experiences.

3. **Who decides on priorities and action?** Reflecting the concerns of question 2, this question focuses on the problems of power and control and is critical to any discussion about community participation. It does not merely reflect the distribution of power and decision-making between planners/professionals and community people but also among those who have various interests in the community. Chambers (1997) has explored the former issue in some detail. The literature on the latter is sadly lacking and is noted as a concern later in this review.

These questions continue to haunt the concerns of both the theory and practice of community participation on which participatory approaches are based. They are addressed in Chapter 3, which looks at some of the concepts about participation and the translation of theory into practice.
CONCLUSION

We have seen that the definitions of both community and participation have been influenced by historical contexts and views of social theory. We have also seen that both context and experience has militated against standard definitions of both sets of concepts. For those who wish to apply these concepts in health projects, it is important to have agreed upon a definition which can be critical to defining programme objectives. The answers to the questions posed above must be addressed to provide a transparent understanding among both planners and beneficiaries about the purpose and expectations of a specific project.

REFERENCES


3. THEORETICAL CONSTRUCTS OF COMMUNITY PARTICIPATION

Summary

In this chapter, we begin by examining the theoretical constructs which have influenced thinking about community participation in the last fifty years and place them in a historical perspective. We look at these constructs in the context of: 1. community development, 2. popular participation, 3. empowerment and 4. action research. We then examine some of the methodological implications for inquiry into participatory approaches, focusing on the use of qualitative methods. We do so because the choice of methods reflects and is reflected in the translation of the constructs into practice. We follow this description by examining the consequences for translating the theory into practice by asking the following questions: 1. How has community participation been analysed in translating theory to practice? 2. What factors influence participation? 3. How do we evaluate participation?

Theoretical constructs

Introduction

Theoretical constructs of community participation are rooted in the constructs of social theory. Interpretations of human relations have given rise to a vast literature on the subject. Of those whose influence has been pervasive in the twentieth century, names like Marx and Weber immediately spring to mind. It is not possible, given the scope of this review, in any way to do justice to the influence of the social theorists. It is important to note that those named above have put in place the theoretical foundations for interpreting society in the twentieth century. In the nineteenth century, it was argued that the study of human behaviour should follow the type of analysis used for the study of natural sciences. Weber was critical of examining human behaviour in these terms. He saw behaviour as actions determined by reason, intention and meaning. His views were opposed by Marx who argued that society was deterministic and that the laws of capitalism were as
predictive as any natural science. These discussions have continued in the arguments about the views about modernity, as history has so far proved Marx wrong about the fall of capitalism. The social theories of today highlight issues of globalisation, rapid information exchange and gender.

While social theory might be seen in terms of methodology, analysis of modernity and/or critique, it is the latter that is of relevance to this review. Social theorists concerned with critique are also concerned with using social theory as a means to understand and change society (Polity Reader, 1994). For example, Habermas examined language in this context arguing that the realm of communications was one in which the reality of power can be assessed. Concern with power and its distribution is critical to the analysis of participatory approaches as we see in the following sections. For those interested in greater details about social theory, the Polity Reader in Social Theory (1994) provides a number of articles which examine the issue of power and those above in some detail.

Community development

The term community development, like the term community participation, has a number of meanings. Its history, described below, helps to account for this situation. In its current usage in health promotion, Labronte (undated) defines community development as efforts to create a new group or organisation, often with outsiders’ help, as well as drawing existing groups together around a specific topic, issue or event. It also can include strategies to address community problems upon the above basis such as health risk behaviours.

Authors of theoretical constructions of social theory were not first and foremost concerned about the socially excluded. In practice it was the public servants – doctors and teachers – who in the Anglo-American world provided much of the care for the poor in the late nineteenth and early twentieth century. By the early 1950s, however, with the decolonisation of the newly emerging nations and social unrest in North America, views about poverty alleviation at the community level began to change. It was recognised that the knowledge and nature of poor people needed to be explored and understood and community, not merely professional needs, needed to be identified. It became a major goal for the community to help itself. The worker thus became transformed from a deliverer of services to a catalyst for change. Community development shifted poverty alleviation from an act of charity on an individual level to concern about communal and sustainable development efforts.

The history of community development can be traced to the efforts of President Theodore Roosevelt in the United States when in 1908 he established the Country Life Commission (Christenson and Robinson, 1980). Activities in this period focused on improving life for rural Americans through creating local organisations
to deal with economic improvements, business and recreation and services. Enabling deprived communities to develop their own resources and become self-reliant was a major goal. In the 1940s, urban areas took up the mantle and transported many of these schemes to the urban poor. Influences from community education, community organisation and social work modified the approaches. Alinsky (1972) developed models of conflict to promote the causes of the poor in both urban and rural America by organising affected groups of people to confront those who were oppressing them. Community development has continued to focus on organising the poor and self-reliance in the late twentieth century.

Midgley et al. (1986) argue that in Europe and the UK, community organisation and community development were heavily influenced by developments in America. However, the model which was basically, despite Alinsky, one of consensus, never fully took root in Europe. Community development here expanded in the area of social activism, organising poor communities to demand and get resources from the authorities. In Britain, community development has had a chequered history which can be described as a tension between community work and social activism. The Thatcher government increased this tension as policies and their implementation focused on state withdrawal of funding for social welfare. Community development workers found themselves in the position of defending the local authorities, a traditional enemy because local government was always seen to give too little too late. Under the Conservative government, local authorities fought hard to maintain their funds and a larger role in social welfare. Thus, the role of the community development worker in defending the poor against the uncaring state, a role also taken by social activists, was diminished. In addition, social activists, different from professional community workers, continued to address community issues outside the context of public assistance such as race/ethnic issues, issues of minority rights including those of the gay community and of the disabled. As a result, during the 1980s community development, seeking to address issues of this nature, found itself with reduced funding. While both community development and social activism agreed upon a larger role for community, they continued to differ on how this role should be developed (Miller and Bryant, 1990).

In the context of international interests and the wider contribution to the theoretical construct, a critical period was that after the Second World War. The emerging concept of community development was embraced by the Anglo-American administrators responsible for relations with the former colonial nations and with less developed countries (the umbrella term for poor countries). The ideas, views and writings which have shaped many aspects of community development have come from these experiences. They gained recognition in international organisations and national governments mainly because of their relevance to the experiences of many of the groups involved in modernisation and economic development. The term was first defined in a report of the 1948 Cambridge Summer Conference on African Administration in response to the British government's efforts to shift the focus in its colonial empire from its concern solely
for law and order programmes to those which included social policies (Brokensha and Hodge, 1969). The definition says:

A movement designed to promote better living for the whole community with the active participation, and if possible on the initiative of the community, but if this initiative is not forthcoming spontaneously, by the use of techniques for arousing and stimulating it in order to secure its active and enthusiastic response to the movement. (Brokensha and Hodge, 1969, p. 34)

The ideas of community development were popularised by the United Nations in the 1950s and early 1960s in the wake of decolonisation. With development concerns at the forefront of policy, the UN saw community development as a means of rapidly introducing modernisation in the rural areas of the non-Western world. Defined by the United Nations, community development was:

... the processes by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate the communities into the life of the nation, and to enable them to contribute fully to national progress. (United Nations, 1971, p. 2)

By linking the ideas of community development to government policy, the promotion of the concept offered, it was thought, a means to rapidly modernise the rural areas. In the early 1950s, only seven countries had national community development programmes. By the early 1960s, the number had increased to over thirty.

It has been suggested that community development in both the industrial and developing countries may be seen as a method, a movement, a programme and a process (Sanders, 1970). As a method, it strongly called on the disciples of social work and was concerned with community structures and community organisations. As a movement it became an ideology. It was seen as a means by which democracy through participation of local people could be spread throughout the world. As a programme, it was based on the following principles: 1. integrated development in which a community plan involving all sectors would be developed to ensure a balance and co-operation among those involved in technical developments; 2. planning based on the community 'felt needs' – that is needs defined by the community not the experts; 3. emphasis on self-help efforts; 4. concern for identifying and training local leadership; 5. technical assistance from the industrial nations to provide personnel, equipment, materials and/or money to ensure improvements in the local situations (Mezirow, 1963). As a process, community development focused on the education approach to development. It aimed to remove the stigma of charity to the poor and to restore their dignity. It also attempted to bring the community at the grass-roots level into the act of decision-making about issues which affected their daily lives.
This approach to poverty alleviation was based on several assumptions. Firstly, it assumed communities were homogeneous, wanting the same things at the same time. Secondly, it assumed that felt needs were easily agreed upon by community members and that self-help was easily gained as a commitment to meeting these felt needs. Thirdly, it assumed that the process of community involvement would remain dynamic and committed despite the growing trend to bureaucratise programmes. Fourthly, it assumed that the educational process creating development would not be absorbed by the incentive merely to gain material improvements (Karunaratne, 1976). In retrospect, these assumptions proved unfounded. As a result, community development lost credibility.

In the context of the entire process of addressing the needs of poor nations and poor people, the views about development in the 1960s began to change. The concept of the transfer of technology to a mobilised and willing group of people which could and would alleviate their poverty proved not realisable in practice. New theoretical constructs began to emerge.

To contextualise community development in the search for understanding about the use and value of community participation in poverty alleviation we can examine its answers to the critical questions identified in Chapter 2. Community development began a shift to address poverty alleviation in terms of community rather than individuals. Essentially, it defined community as a geographic entity and sought universal solutions for problems of poverty. The result was, it might be argued, a rather mechanistic approach addressing issues of community structure and community organisation rather than community relationships. Community development saw the solution to poverty alleviation as a static, replicable model of control change rather than a dynamic, locally based solution. The issues of power and control were rarely directly addressed. Community participation, defined and directed by experts who knew what was good for the poor, was seen as a means by which the end product – life improvements – could be delivered; it was not the means by which the product would be sustained.

**People’s participation**

By the 1960s, the programme experiences in community development began to question the values put forward in the community development construct. The situation began to demand the need to deal with conflict in community settings because communities were not homogeneous and those who had power and wealth were not prepared to share it with those who did not. The term ‘people’s participation’, which entered the international dialogue in the 1960s and was popularised by the United Nations agencies, provided an umbrella for work in this area. Popular participation or people’s participation, which became a more usual term for these ideas, focused on the need for structural transformation in the social, economic and power relationships between those who had material goods and
opportunities to improve their life circumstances and those who did not.

The work of Stiefel and Wolfe (1994) traces in great detail the origins and concerns of the construct of people's participation. Both were involved in the research into the subject undertaken by the United Nations Research Institute for Social Development (UNRISD) which began in the 1970s. Essentially, the studies confirmed that development of the poor would continue to be limited unless the question of the redistribution of power to those who had little was addressed. The work of UNRISD was, in part, devoted to researching and advocating ways in which such an endeavour could be undertaken.

A Voice for the Excluded by Stiefel and Wolfe (1994) documents the experiences of exploring, implementing and advocating a shift in power from the elites to the excluded. It details the growth of concern in the area of social development in both the conceptual aspects and actual case study experiences. The analysis focuses on both the theoretical and practical consequences of power and participation.

For the purposes of this review, the most relevant part of the study is the chapter on participation in the 1990s. Firstly, Stiefel and Wolfe suggest that the economic constraints of this period have not only created a new group of those who are marginalised but have also brought into focus the relationship between the poor and the state. As the state is no longer able to provide the welfare benefits which the less fortunate have come to depend upon, these people have begun to question the legitimacy of the state. This situation has meant that new approaches for creating identities of communities are taking place by searching for democratic processes in the context of either nationalist or religious–sectarian forms.

Secondly, the newly democratised nations have not necessarily provided wider organisational efforts to address the needs of the poor. This situation is a result of the lack of the capacity of the existing formal democratic structures to respond to problems of those marginalised by these structures. The existence of a democratic state does not provide the wherewithal to ensure that community organisation will grow to prevent the return of an authoritarian state.

At present, the search for new forms of community organisations to help protect and act for the concerns of the poor are assisted by non-governmental organisations (NGOs) and the authors advocate that NGOs should be strengthened. However, in many situations, the state regards the NGOs as potential enemies and rejects possible partnerships which would benefit the poor.

Despite this rather dismal description of the present state of affairs, the authors say that today participation, democracy and self-reliance have a highly regarded place in the development dialogue, thus helping to create a privileged place for participatory action on this agenda. The international agencies, including the World Bank, recognise that lack of participation is one of the five main reasons that aid-
supported projects fail. One of their conclusions is that the revival of participation is an acknowledgement that past approaches (lacking participation) have failed to solve the problems of poverty. Renewed interest leads to fresh hope of addressing the problems of massive poverty.

People’s participation directly addressed power relationships, often advocating new social structures to empower the poor with the threat of removing power and advantage from those better off. The UN agencies which advocated and supported people’s participation because of its human rights and social justice implications, became more cautious when promoting the ideas in project implementation. One result was the attempt to equate community participation with people’s participation and use the terms interchangeably. Shrimpton (1995), who works for UNICEF, illustrates this tendency in his article on community participation and nutrition programmes. After reviewing various dimensions of participation including the question of shifts in power, he goes on to state ‘All agree, however, that community participation is not political participation but the active involvement of a community in the development process or process of change’ (p. 245). This interpretation would be challenged by advocates of empowerment as we shall see below.

Another consequence, again in terms of attempting to translate theories into practice, is the introduction of the term ‘stakeholder’ into the participation dialogue by the World Bank (World Bank, 1996; Nelson and Wright, 1995). The term itself is of interest in the context of participation of the poor. The Shorter Oxford English Dictionary defines stakeholder as ‘one who holds the stake or stakes of a wager’. A stake is defined as that which ‘is placed at hazard; a sum of money, etc. deposited or guarantee, to be taken by the winner of a game, race, contest, etc.’ (Shorter Oxford English Dictionary, 1985, p. 2102). In using this term, the poor of the development projects are seen as gamblers for life improvement rather than the guaranteed recipients of resource redistribution. Participation is risk, not a commitment for opportunities for betterment. The Bank states that it is important to involve all those who have concerns in the development process, as bypassing the rich and powerful often raises resistance which is difficult or impossible to overcome. Those who advocate structural change as the means by which the poor will gain access to improvements, take issue with this concept as a participatory approach. They point out that once again the issue of power and control is diluted so that the project product takes precedence over the process. They believe such an approach will continue to limit a more powerful role for the poor.

The construct of people’s participation directly takes on board the questions posed at the end of Chapter 2. It has through objectives and advocacy defined communities as ‘the poor and dispossessed’. It has argued that community participation is a means by which the poor get access to resources through social transformation and it is an active process. The final question – who decides – professionals or community? – becomes clear as the further expansion of this
conceptual development in the construct of empowerment. It is to this construct we now turn our attention.

**Empowerment**

The term empowerment is one closely related to people's participation. Entering the dialogue in the 1960s, as did people's participation, it focused the debate on power with the concept that some people could act to help others to gain power and/or to help the powerless to realise their own potential (Nelson and Wright, 1995). The concept is closely associated with the work of the Brazilian educator, Paolo Freire who saw education as a political and social means of changing power relationships (Wallerstein, 1993).

Contributions to the concept were also made from the field of community psychology and associated with the work of Rappaport (Hawc, 1994). In the early 1980s he argued that empowerment was the process by which communities could reach their goal of a community identity. He further argued that empowerment was to be defined in the context of both capacity and equity to ensure communities would be able to solve problems as well as obtain a fair share of the resources to implement these decisions.

Empowerment in its broad sense has come to mean 'people gain control in their own lives in the context of participating with each other to change their social and political realities' (Wallerstein, 1993, p. 219). This latter definition reflects the need to address powerlessness in its social context. Nelson and Wright (1985) identify three models of empowerment. The first two are related to empowerment in practice; the third is a theoretical interpretation of power and not so relevant in this review. The first model is identified as a 'power to' model which sees power as unlimited and the gaining of power by an individual not necessarily at the cost of another individual. In this model, it is possible for a change in the power relationship to benefit all parties. It addresses the issue of capacity building and developing potential of the people. Although it runs the risk of focusing on individuals rather than larger aggregates of people, many authors have used it to deal with collective action.

The second model is the 'power over' model which addresses the issue of gaining access to political decision-making. In this model, the gain of power by one person or a group of people is at the cost of loss to another. It is a conflict rather than consensual model which in its extreme form results in social revolution.

Empowerment has been addressed by a number of writers in both the industrial and developing country contexts. One of the most prolific is Robert Chambers who has clearly translated the idea of empowerment in action programmes in a wide range of contexts. He spent many years in rural development analysing poverty and
poverty alleviation, mainly in poor countries. On this experience, he concludes that the only sustainable efforts are those in which the poor take responsibility and action for improvements and the experts give up power and control over project outcomes. His latest book *Whose Reality Counts?* (Chambers, 1997) is a clear and enthusiastic articulation of his ideas. A more academic discussion can be found in his three articles for *World Development* (Chambers, 1994a; 1994b; 1994c).

A summary of Chambers's main points concerning the empowerment argument is published in Nelson and Wright (1995). Essentially he reviews the evidence that professionals have the monopoly of knowledge concerning the process of social and economic improvements. He strongly suggests that the local people who have been concerned all their lives with seeking improvements actually have a great deal to contribute to this process. Consultations between professionals and locals is one step to improving the situation. However, it is limited. For maximum effect, the professionals must 'hand over the stick' (in other words give up their power and control) to local people who must take responsibility for a project from inception to evaluation. Addressing the needs of the poor through a mutual education process enhances the capacity and the confidence of locals to take charge of their own lives.

Chambers argues that local control of decision-making is not merely an administrative action. Rather it is a paradigm shift which: 1. recognises the ability and capacity of non or poorly educated people to carry out tasks defined and formerly carried out by experts; 2. allows innovation to be spread by peer groups rather than by a top-down professional; 3. uses visualisations (which we explore in some detail in Chapter 4) to create an environment where information can be rapidly generated and modified. This situation allows the outsider both to assess the validity of the information and facilitate participation of those in the group that are shy or reluctant to speak; 4. brings about a role reversal where the experts need to establish rapport with the locals by changing their behaviour and attitudes toward working in poor communities.

In the field of health, Wallerstein (1993) has considered some of the concerns of the theoretical construct of empowerment. She reviews the literature which gives evidence that those who view themselves without power and control over their own lives have worse morbidity and mortality indicators. She also reviews the conclusions of work in community psychology which supports this evidence. Her discussion focuses on the use of education as an empowering tool which corresponds with Chambers's views. Experts acting as facilitators enable people to identify their own problems, be critical about the roots, social and cultural, of these problems and to develop strategies to address these problems in a positive way. Her own example of an alcohol and substance abuse programme in New Mexico is used to illustrate the application of the Freirean education philosophy (Wallerstein, 1993). The programme brought teenage volunteer students together to talk with those who suffered alcohol and drug abuse and their families with the aim of reducing excess morbidity and mortality among middle and high school students.
from high-risk low-income multi-ethnic communities. Using the Freirean method of codes to explore meaning and developing dialogues among participants, the programme helped these teenagers to set targets for gaining self-respect and avoiding at-risk behaviour choices. By setting achievable targets and meeting these targets the participants gained a sense of confidence and control over their future. The interaction with those who suffer abuse problems also enabled this group to reflect about ways of overcoming problems.

The construct answers the questions posed at the end of Chapter 2 in the same way as does the people's participation construct. It does provide in some detail, as we have seen, answers to the question of who decides priorities and action. In this sense, it might be argued that the empowerment construct is an elaboration of the people's participation construct. All three constructs are considered 'bottom-up' rather than 'top-down' in terms of their planning and programme implementation approaches. However the latter two differ from the community development construct because they directly address issues of power and control. The community development construct, as we have seen in section 2 'Community development' above, avoids addressing these issues by assuming consensus and universal approaches to all situations.

**Action research**

Action research has become increasingly popular during the last three decades. Hart and Bond (1995) have written a book which, among other contributions, traces its developments by providing examples in the field of health. Its antecedents can be found in the work of a German immigrant to the United States in the 1940s. Lewin, a psychologist, addressed the issues of linking the naturalistic view of social sciences with social action to address major social problems. He saw action research as a method of planned social change using systematic research and social experiments to improve social situations. He used the situation in an American factory which was having trouble with workers over restricted employment practices necessary to compete effectively in the existing market. Lewin hypothesised that frustration among workers arose because of the conflict between the drive to reach the standard rate of production defined by the job and the problems with the difficulty of the job. Lewin examined the level of frustration of workers by documenting three different approaches to the changing situation. He divided workers into three groups – one which had not participated in management policies; one which had participation through representatives and the third which had full participation. He then documented the type and level of worker frustration in each group. He found a greater level of worker satisfaction in the group which had greater representation. This action research confirmed Lewin's belief that democratic participation in management was more productive than autocratic coercion associated with theories of scientific management.
Lewin's action research consisted of a four-step framework of planning, acting, observing and reflecting and forms the basis of modern action research. Evaluation of the research is key, as it determines whether the research has led to improvements. The process combines empirical research and direct applications of the findings.

Applied to American industry in the 1940s, it was taken up in Britain in the context of community development projects in the 1960s. Directed at poverty alleviation, the approach became critical to give evidence that poverty was not the result of the victims' inability to improve individual lives but rather a reflection of the entire social, political and economic circumstances in which people lived.

Action research differs from the more traditional theoretical and applied research in the following ways: it seeks to solve a specific problem; disseminates the information gathered through feedback in order to bring about a desired change; attempts to generate a sense of ownership of the information by the beneficiaries in order to gain their support for the change programme; recognises the key role of personalities in research information and outcomes and the political nature of research, thus demanding careful preparation to take account of these contingencies.

More specifically action research has the following characteristics as defined by Hart and Bond (1995). It:

- is educative;
- deals with individuals as members of social groups
- is problem-focused, context-specific and future-oriented;
- involves a change intervention (has a specific intervention to seek an identified change);
- aims at improvement and involvement;
- involves a cyclical process in which research, action and evaluation are interlinked;
- is founded on a research relationship in which those involved are participants in the change process.

The application of action research can be seen as a continuum, where at one end there is experimental research placing priority on a rigorous application of the research process and at the other there is empowering research which places priorities on the processes by which the researched group gains access to the skills and information the research process generates. The matrix from Hart and Bond (1995) which describes these characteristics is presented in Chapter 5 as the analytical framework for the case studies.

Action research has been the framework of participatory research which we examine in Chapter 4. It might be seen as the application of the more theoretical
notions of people's participation and empowerment. The answer to the three critical questions at the end of Chapter 2 echoes the answers to the two previous constructs. It supports the view that participation is a means of social transformation in which the poor define their own communities and have tools to empower themselves to gain confidence and experience to transform and sustain an improved situation.

Table 5. Summary of theoretical constructs of community participation

<table>
<thead>
<tr>
<th>Theoretical construct</th>
<th>Year</th>
<th>Focus on participation</th>
<th>Main authors</th>
<th>Answers to critical questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community development</td>
<td>1950s</td>
<td>community structure, community organisation</td>
<td>Ross, Mezirow</td>
<td>Who defines community?</td>
</tr>
<tr>
<td>People's participation</td>
<td>1960s</td>
<td>structural transformation</td>
<td>UNRISD, Stiefel and Wolfe</td>
<td>CP a means or end?</td>
</tr>
<tr>
<td>Empowerment</td>
<td>1960s-90s</td>
<td>'power to' 'power over'</td>
<td>Frere</td>
<td>Who decides priorities and actions?</td>
</tr>
<tr>
<td>Action research</td>
<td>1980s-90s</td>
<td>participatory action research, participatory research</td>
<td>Lewin, Fals-Borda and Rahman, Hall</td>
<td></td>
</tr>
</tbody>
</table>

Methodological issues for participatory approaches

A consideration of methodological issues is crucial for planners. These issues emerge at all stages of planning from initiation to evaluation. One major consideration and the one on which we shall focus because of its implications for participatory research and research approaches is the question of the use of quantitative and/or qualitative methods for programme planning, implementation and evaluation.

In the field of health and medicine, traditionally quantitative methods have been used to assess and evaluate the range of concerns from clinical interventions to public health programmes. These methods are designed, in part, to show the magnitude of the problem. They are the basis of descriptions for scientific experiments and planning for epidemiological and public health analysis. They are associated with 'positivism'. They are used for hypothesis testing, establishing
causal laws and predication of future outcomes (Walker, 1985). Because of the presentation of these methods for both case reports and in journal articles, as Keen and Packwood (1995) point out, health professionals today still use quantitative methods to make most of their decisions.

Qualitative methods, on the other hand, look at the world in a set of social constructs. They seek to identify how individuals and groups perceive the world around them and to find different views of reality. In the health field, people are not so familiar with qualitative methods and are not as comfortable in using them. Recently, however, their contribution to health planning and management is being recognised. To have interventions accepted, planners need to know how cultures, societies and people view both health and the identified intervention. As quantitative methods are not able to provide this information, interest has grown in qualitative research. AIDS is a recent example where qualitative methods are more suitable because they allow in-depth probes about personal behaviour. Yach (1992) points out that the concern about this disease was one reason the qualitative methods gained a more prominent place on health research agendas because the control and prevention of this disease depends on choice in human behaviour not on the administration of medicines.

Patton (1990) identifies nine themes of qualitative research which distinguishes it from quantitative inquiry. These are:

1. naturalistic inquiry – studying the world as it is rather than attempting to manipulate to test how it could be
2. inductive analysis – looking at details to describe a situation rather than testing a hypothesis
3. holistic perspective – seeing the phenomenon under study as more than the sum of its parts and looking at the interdependence of these parts rather than the cause-and-effect relationship
4. qualitative data – collecting detailed data recording people’s experience rather than numerical reduction of selected aspects
5. personal contact and insight – involving the researcher with the people being studied to give the researcher insight rather than refraining from any personal involvement with the subjects
6. dynamic systems – paying attention to process rather than the outcome and/or impact
7. unique case orientation – assuming each case is special and capturing the uniqueness of that case rather than looking for generalisations which can be done by cross-sectional analysis depending on the quality of the cases
8. empathic neutrality – using personal insight and understanding to enhance the quality of the data but not advocating or judging situations based on personal feelings and emotions
9. design flexibility – adapting inquiry methods as understanding deepens or the situation changes rather than having a fixed instrument to use on all occasions

One methodological issue is the question as to whether, given the underlying conceptual constructs of the methods, both methodologies can be used to consider the same research question. Pedersen (1992) examines the question in some detail using the survey instrument as an example to show how both methods complement
each other to improve validity for the information acquired. He highlights the fact that both methods contribute to the triangulation process strengthened by the use of multiple methods to investigate a specific problem. One of his conclusions is that the use of qualitative methods in health research is ' ... a sine qua non for expanding the conventional epidemiological and biomedical model; for re-orienting health plans and programmes; and for designing more effective health interventions and evaluative models' (p. 45).

A Health Education Authority study by Rogers and her colleagues (1997) examines the use of qualitative methods to investigate health-related actions in the context of health inequalities. The report reviews the literature, using qualitative methods to help in understanding health choices of the socially excluded. The first part of the study looks at the use of these methods for investigating specific research questions. The second part focuses on setting standards for qualitative research. The final section reviews their own methodology for the report. This publication directly addresses the use and value of qualitative research in understanding health behaviours and clearly describes the ways in which it should be undertaken.

Qualitative methods have a critical role to play in participatory approaches both in research and project development. Because most methods are interactive, that is they involve the informant in the information collection exercise, either actively or passively, the informant takes part in the learning process in which the researcher is already engaged. Particularly in interviews and methods of visualisation, the informant can actually take control of the data collection processes which provide both information and empowerment for that individual. The use of these methods can result in a situation where data collection is valued as a process in and of itself not merely as an activity for the product of information. It reflects the orientation of Korten (1980) who suggests development activities have greatest chances of success when seen as part of a learning process rather than an administrative blueprint.

The participatory appraisal framework in particular generates a specific set of characteristics which lend themselves to qualitative methodologies. These include:

- community involvement in information collection and analysis;
- holistic and systematic approaches;
- multidisciplinary and interactive methods including visualisation of information to replace only verbal communication;
- flexible responses;
- emphasis on communication and listening skills;
- action-oriented research to be used by planners and managers for problem-solving (Rifkin, 1996a).

Thus, qualitative methodology provides both a means to improve the quality of information as well as, critical for participatory involvement, a systematic approach to give opportunities for non-professionals to gain skills and experience as well as
information in order to improve their life circumstances. This improvement, in terms of the community, has the potential to address both the issues of power and access to resources and material benefits.

**Critical questions for translating theoretical constructs into theories for practice**

**How is community participation analysed?**

In Chapter 2 we briefly review definitions of participation. In this section, we review major analytical frameworks developed to understand participation mainly as an intervention to improve the life situation of the poor. These frameworks had the objective of enabling planners to translate theories into practice. The question of power and control discussed above remains central to these frameworks but in some cases is not directly addressed. Addressing this issue means dealing with conflict which could limit or deflect the outcomes the planners seek. In this case, it might be argued that the defined outcome (product) takes precedence over the process.

This section looks at how community participation has been analysed in a framework. The second section examines the interpretations concerning the various levels of participation. The third section reviews an article which suggests that analytical frameworks developed so far have been inadequate to enable planners to formulate realistic expectations about the role of community participation in health care.

**Comprehensive frameworks**

The classic work on investigation of participation as part of the development process was undertaken by Cohen and Uphoff (1980). They attempted to examine participation by asking: 1. what kinds of participation – was it participation in decision-making, in implementation, in benefits, in evaluation; 2. who participates – local residents, local leaders, governmental personnel, foreign personnel; 3. how is participation occurring – is it coming from above or below, are there incentives or is it voluntary or cohesive, what are the channels; 4. what is the structure, duration; 5. does it give people opportunities for decision-making by building capacities to benefit from the results of their participation? Their study (Cohen and Uphoff, 1980, p. 227) concluded with some generalisations which still hold after nearly twenty years of further experience of participation in both development and more specific sector projects. These conclusions are:

- participation is not one single thing;
- participation is not solely an end but it is more than a means;
- participation is not a panacea for community problems;
participation in development is not the same as participation in politics;
participation in development, however, is inescapably political.

The work of Cohen and Uphoff set the stage for further theoretical work on participation in development and social programmes. Bracht and Tsourous (1990) using this framework described principles and strategies for effective community participation within the WHO framework of Health for All (HFA). It became the structure for the WHO 1989 Health Cities Symposium. Bracht and Tsourous address the way in which local people can organise formally and informally in order to effect action in health. Based on experiences in Western Europe and North America, they focus on issues and relationships and organisational structures to promote community participation in health. Figure 3 summarises the main themes discussed in the paper answering in some detail the questions Cohen and Uphoff’s analysis proposed.

**Fig. 3. A framework of citizen participation**

Source. Bracht and Tsourous (1990)

They identify two main approaches to citizen participation (their word for community participation). The first is participation in the formal decision-making
mechanisms whereby people participate in policy formulation, planning and/or implementation of decisions. Examples cited here include: involving local community members in official decision-making bodies; getting advice from local groups about new project proposals and keeping local people informed about policy decisions and developments. The second is the participation in community-level activities. Examples here include a broad spectrum of groups who are involved in health activities, such as self-care groups, voluntary organisations and social movements, such as the women's health movement.

Rifkin (1985), also using the Cohen and Uphoff framework as a basis, developed a model which described the approaches to participation which could be found in health projects and programmes. She identified three types of approaches to participation: the medical approach, the health planning approach and the community development approach. The medical approach is one which has its roots in the medical model of health care. It argues that the best way of improving health is by applying advances in medical science and technology to combat disease among large groups of people. It interprets community participation as the community responding to professional direction and expects that through increased knowledge and professional guidance people will take action to improve their health.

The health planning approach views health improvements as a result of the appropriate delivery of a health service. It argues that medical/scientific advances and technology should be integrated in health care in order to ensure better health status and that this can only be done with consultations and contributions of community members. In other words in the approach the community participates in both the delivery of and the type of health care provided. These two approaches, she notes, are 'top-down' with the professionals providing content and direction of the participation.

The third approach, the community development approach, argues that health is a human condition and therefore is not a mere reflection of the availability of health services. This approach believes people have the right and duty to be involved in decisions which affect their own lives. It sees health as a result of a range of factors within the environment and health improvements as a result of the community developing the capacity to identify and act upon problems – not merely disease problems – which will result in improvements. In this approach community members begin to take control and create capacities to act upon the conditions responsible for poor health and related poverty.

The community development approach, a 'bottom-up' approach reflected a growing literature on the nature of participation in terms of individual and community empowerment. In this literature, the questions of means/end; process/product; active/passive once again moved into the limelight.
Unlike the Bracht and Tsourous (1990) framework, the Rifkin analysis confronts the issues of power and control in her analysis of the community development approach. The former discussions do not investigate the diversity of interests among a specific group of people and assume consensus rather than conflict. Rifkin (1985) illustrates how the theory of Bracht and Tsourous works in real situations. She suggests that the consensual model described by Ross and Lappin (1967) and identified with the writings on community development in the 1950s and early 1960s is weak.

The community health worker (CHW), becomes the most obvious example, of the two interpretations in practice. Originating from the Chinese barefoot doctor, a local person trained to provide simple first aid, preventive work and health education, the CHW was to provide both scarce health services at the local level and act as an agent of change in the Freirean model of building social awareness (Walt, 1990). The category of worker met the community development criteria of community people defining their needs and providing resources (the worker to meet these needs) as well as helping communities build capacities to sustain the change in health care and health improvements. Werner (1981) examines the conflict which arises when one person tries to encompass both the role of the service provider and the change agent. In his article, 'The village health worker – lackey or liberator?', he suggests that the power of the medical profession and those who benefit from services militates against change which would allow lay people to be truly involved in the process of providing health care. If the change were to occur, he argued, not only would non-professionals have access to medicines and information which could be misused but also, though not so clearly articulated, they would undercut the monetary rewards, power and prestige of the doctor. Walt (1990) examines three case studies which support Werner's arguments. In programmes in Sri Lanka, Colombia and Botswana trying to translate community participation into CHW programmes eventually resulted in the CHW becoming a service extender. The CHW was unable to fulfil the role of an agent of structural transformation necessary, as argued by people's participation, to address the roots of poverty alleviation.

Levels and stages of participation

In accepting community participation as a process – whether a means or end – several authors have tried to articulate the development of that process either by describing levels or stages of participation. We review briefly below three which address the issue of participation in health.

The classic model is one presented by Arnstein (1969) in which she identifies six levels and relates them in the matrix to the degree of power each represents (Table 6).
Table 6. A ladder of participation

<table>
<thead>
<tr>
<th>Citizen control</th>
<th>Delegated power</th>
<th>Partnership</th>
<th>Placation</th>
<th>Consultation</th>
<th>Informating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degrees of citizen power</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degrees of tokenism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Arnstein (1969)

In a more elaborate model, modified by those involved in rural development work in developing countries, Cornwall (1996, p. 96) in her matrix addressed the question of whether community participating is a means or an end. Like Arnstein, she elaborated a continuum which ranges from manipulation to community control.

Table 7. Participatory methods – means to what ends?

<table>
<thead>
<tr>
<th>Mode of participation</th>
<th>Involvement of local people</th>
<th>Relationship of research and action to local people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-option</td>
<td>Token, representatives are chosen, but no real input or power</td>
<td>On</td>
</tr>
<tr>
<td>Compliance</td>
<td>Tasks are assigned, incentives, outsiders decide agenda and direct the process</td>
<td>For</td>
</tr>
<tr>
<td>Consultation</td>
<td>Local opinions asked, outsiders analyse and decide on a course of action</td>
<td>For/with</td>
</tr>
<tr>
<td>Co-operation</td>
<td>Local people work together with outsiders to determine priorities, responsibility remains with outsiders for directing the process</td>
<td>With</td>
</tr>
<tr>
<td>Co-learning</td>
<td>Local people and outsiders share their knowledge, to create new understanding, and work together to form action plans, with outsider facilitation</td>
<td>With/by</td>
</tr>
<tr>
<td>Collective action</td>
<td>Local people set their own agenda and mobilise to carry it out, in the absence of outside initiators and facilitators</td>
<td>By</td>
</tr>
</tbody>
</table>

Adapted from Cornwall (1996)

In a book on health promotion at a community level, Bracht and Kingsbury (1990) put forward a systematic approach by which community participation might be
developed and strengthened. These stages are: 1. defining the task/making the
diagnosis, 2. planning/design and initiation, 3. organising/implementation,
4. motivating/maintenance, 5. evaluating and setting an example (Bracht and

This model has been translated and modified by Hilderbrandt (1994) based on her
work in a black township in South Africa. The design was directed at improving
health and care for the elderly by firstly doing a survey to identify the problems and
then, with the target groups and their families, prioritising needs and initiating
programmes to meet these needs. The model is one which elaborates a step-by-step
process for involving lay people in project interventions.

Questioning the expectations

The discussions about community participation, in the literature reviewed, suggest a
search for participation in the context of an intervention by which improvements
can be sought. In this context, expectations about the use and value of participation
for social development programmes are the belief that a 'magic bullet' might be
found which will ensure the participatory approach will bring about this outcome.
Rifkin (1996b) argues that the expectation is unrealistic. In her article, she traces
the expectation as emerging from the paradigm in which natural science is
embedded, the linear paradigm. She describes the characteristics of that paradigm
as objective, universal and predictable. It allows planners to believe that
programmes with community participation as an objective can be planned and
controlled. However, she suggests that experiences in community participation
show that it is a process which creates its own dynamics. It is better to see
community participation in an adaptive change paradigm incorporating feedback
loops allowing for experiences to be taken up and applied immediately to the
project. This view suggests that community participation must be examined in a
local context and predictive and/or universal outcomes are not realistic.

An example of the adaptive change paradigm can be seen in the development of
rapid appraisals which we discuss in detail in Chapter 4. In the case of the
participatory appraisals, the exercise is not hypothesis testing about what
intervention works. Rather it is about collecting and analysing information which is
then fed back to programme participants where changes are made to correct the
direction of the programme. The process, in addressing local situations is flexible,
iterative and innovative. Progress is not always achieved but learning is achieved
even when there is a setback.

This approach to community participation is relatively new. The literature does not
record responses to date. However, similar views are being expressed in the
literature concerning rural development by Booth (1994) and his colleagues and the
sociological approaches of people like Anthony Giddens (1997). Booth offers a
critique of the rigid, linear approach of Marx and his views about society by
arguing the need for an analytical framework which accounts for diversity, relevance and choice. Giddens, tracing the linear framework back to eighteenth-century Enlightenment and the Age of Reason, argues that the assumptions of rationality on which these constructs are based are becoming less relevant in a world dominated by rapid information, a business culture and the globalisation of both of these developments. Essentially, Giddens argues that the more information we have does not mean that we understand the problem better in order to solve it, a basic concept of the Enlightenment. These explorations suggest that in the present world, people must, to use Giddens’s phrase, continually ‘reflexively reconstitute’ themselves, and thus the predictability of the future and the assurance of progress can no longer be taken for granted.

**What factors influence participation?**

In attempting to translate theory into practice, several authors have tried to identify factors which influence participation in projects. Those reviewed below give a flavour of the search but by no means a comprehensive investigation of the literature.

Woelk (1992), addressing cultural and structural influences on community participation in health programmes in the developing countries, identifies several factors which facilitate participation. These include, firstly, working in a culture which is not highly stratified. Indian communities, for example; divided by history and by caste proved difficult environments. Secondly, working in communities where there is both a supportive environment and political framework. He cites the work of Morgan (1990) in Costa Rica which illustrates this point. With aid from the US, which wanted to identify health symbolically with Western democratic ideology, Costa Rica developed a strong primary health care programme based on involving community participation. However, when this initiative no longer was a priority of the US political agenda, when foreign assistance was cut and when economic problems turned the political environment into one where the credibility of the state was beginning to be questioned by its citizens, the primary health care programme based on community participation virtually collapsed.

A third factor is working in a situation where there has been a history of common struggle. The history of political struggle of the poor to gain access to resources and rights from the government provides examples. Hollnsteiner (1980) examines the impact of this factor in the context of urban housing and squatter settlements in the Philippines. Analysing the experience by defining and illustrating modes of participation in the struggle to gain land for those whose need was greatest but whose legal claims were weak, she records how the bonding experience enabled people to work together, to organise and to struggle to win and sustain their claims. The process of struggle was the common bond to ensure continued success. Saul Alinsky (1972), recalling his own experiences in organising the poor in the urban ghettos and in labour union politics in America, confirms the value of common
struggle. In his *Rules for Radicals* he argues that unifying against a common cause and winning limited victories in that cause creates confidence in the necessity to organise and to struggle together. He notes that one of the major tasks of any community organiser is to forge organisation through the experience of struggle.

A final factor is working in programmes which interpret health as part of large community empowerment programmes and work inter-sectorally to achieve broad rather than only sector goals. Experiences from developing countries show that health is rarely a priority except when a person is sick (Rifkin, 1985). Research from small non-government programmes in Hong Kong, Indonesia and the Philippines investigated how local people perceived participation in their community health programmes. The study gave evidence that local people wanted the programme to provide drugs and services for their illness needs. They did not want to become involved in the management or the delivery of services even though the planners in the case study in the Philippines argued that to be involved in these activities would empower them and build their capacities to change their poor life circumstances. They had other priorities including increasing their income, tending their fields (in the case of the Philippines and Indonesia) and dealing with other welfare problems. Programmes which were more directed to immediate needs but have a health component are more likely to gain participation than those which do not.

Bracht and Tsourous (1990) identify factors emerging from the Western Europe/North American experience. These factors are: 1. the question of the complexity of social structures and demographic components in the area, whether the area is homogeneous or fragmented by different incomes, classes and geographic orientations; 2. the way in which issues are crystallised and the nature of pre-existing values in the community such as a history of common struggle or common history of any sort; 3. the way in which a community is striving for common goals; 4. the degree of the accountability and identification of the facilitator or group promoting the change; 5. the way in which groups see they have control over their future or alternatively become fatalistic; and 6. the experience people or groups have in community life.

Bracht and Tsourous (1990) continue by discussing how these factors need to be taken into account when establishing a community programme and point to the necessary extensive planning efforts required. The thrust of the article suggests ways in which good planning can overcome barriers which these factors could bring about. Rather mechanistic in their approach, they do not deal with issues of power and control which Woelk (1992) uses to illustrate factors influencing community participation.

In her work for the World Health Organization, Rifkin (1990) identifies two sets of factors which influence participation in a specific project. Her descriptive factors correspond to many of those already identified. She goes on to identify six action factors. These include:
• how involved community people become in making the needs assessment
• whether the outside planners promote a new organisation for the health programme or whether it is integrated into existing organisations
• whether professionals or community people are responsible for managing the programme
• whether resources are provided from outsiders or from the community itself
• whether the local leadership is responsive to the poorest members of the community
• whether the project responds to the needs of the very poor.

With colleagues she later turned the action factors into indicators for evaluating participation which is discussed in the next section.

How do we evaluate participation?

For planners, the need to know if they have achieved project objectives is critical for success and further development. In many health programmes where community participation is a stated objective, planners want to know if it has been achieved. To date, this history of evaluating participation shows that there is no universally accepted model. In part the reason reflects the inability to find a common definition of what it is to be evaluated. In part, it has already been argued that expected outcomes may not be realistic. The review of attempts to evaluate participation is important, however, for those who are seeking to use participatory approaches for a research strategy. For this reason, we address the issue in this literature review.

At the onset, it is important to recognise that there is a difference between evaluating participation and participatory evaluation. The latter is the application of tools and techniques for participatory approaches by those for whom the projects were designed. The former is the assessment of whether the objectives set for participation have been achieved in the programme. We therefore, in this section, focus on the former.

Identifying appropriate indicators

Evaluations of successful social development programmes are very often concerned with indicators to show this success or failure. The search for indicators, however, has only recently been of interest. Hansluwka (1985) traces this interest, in the context of health programmes. He suggests that this search for indicators is a result firstly, of the recognition in the health field that reduction of disease alone is no longer an adequate measure of health status in the population. Secondly, it is a result of the worldwide fascination with quantitative measurement as a result of the influence of economic theory and policy influencing the social sciences and the social science debate. He also suggests that the advent of PHC has created a new emphasis on indicators for improved health. However, he notes the stress on
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indicators has provoked some difficulties. Indicators are usually seen as a means of measuring an outcome and thus are based on quantitative methods. Problems of actually measuring equity and participation, let alone health, as the social, physical and mental wellbeing of the individual are among the most prominent.

The limitations of outcome indicators

The biomedical field is dominated by the use of quantitative methods to assess progress. It is no surprise then that indicators for participation have sought the measurement numerically to evaluate programmes. For example, a recent article (Oddy et al., 1995) uses these methods to measure the rates at which different strata of a specific population ‘participate’ (in this case to be present) in community health promotion activities. On the basis of this examination, the authors conclude the project has been successful in reaching disadvantaged youths. The assumption here was that attendance at programmes implies the behaviour change on which the health promotion activities were targeted. This assumption, as we see below, has been challenged.

WHO, among others, recognised the weakness of using only quantitative methods. In its Health for All series detailing ways to implement PHC, No. 4 entitled Development of Indicators for Monitoring Progress for Health for All by the Year 2000 (1981) specifically lists a long series of indicators for PHC. Here it notes that in evaluating community involvement (WHO’s term for community participation) only qualitative indicators might be possible.

Despite this argument, within the WHO experience articles were written to track the development of community participation by quantifying results. Based on experience in Bolivia, Agudelo (1983) presented a framework which used both qualitative and quantitative information but in the end assigned numbers to certain activities for health workers such as health promotion and supervision. He then suggested that quantifying the results would reveal the range and completeness of community participation.

Documenting experiences of evaluating community participation in WHO’s Pacific Region, Palmer and Anderson (1986) describe how the regional offices asked countries for: 1. the percentage of local communities with well established organisations and commitment for PHC and 2. the percentage of the community’s contribution. This evaluation form again illustrates the emphasis placed on quantitative results.

It is fair to say this early approach to evaluation did have some strengths. For example it provided a universal framework by which community participation activities could be identified and their spread explored. As both a preface and a result, it attempted to begin to define the term. Secondly, it was a familiar framework to health personnel who had experience in measuring and quantifying
activities. It thus helped to make more acceptable lay participation in fields that traditionally have been dominated by professionals.

The quantitative approach, however, had some serious weaknesses. As pointed out by Palmer and Anderson (1986) the assessment tools were weak as definitions such as 'commitment for PHC' or 'evidence that health committees are no longer dependent on an external agent' are notoriously difficult to define. In addition, the physical presence of a person in an activity or at a meeting did not indicate active participation. It only indicated presence. Most critical was that planners who were asked to assess participation in programmes did not find these tools helpful. Purely quantitative approaches never did gain extensive use either in local, national and regional programmes.

The development of process indicators

In the mid-1980s recognizing some of the weaknesses of the mainly quantitative approach of the early attempts and coinciding with the concerns of researchers and workers in wider development programmes, focus gravitated to examining the process of community participation. The impetus was to give planners some tools to assess whether participation was active or merely passive and to investigate participation as a means of empowering people – especially the poor and oppressed.

From the development field, the suggestion of looking for 'process indicators' gained currency. Oakley (1990) examines this impetus in great detail in his chapter in *Evaluating Social Development Projects* (Marsden and Oakley, 1990). Discussing social development projects, in which health projects are prominent, he argues participation is notoriously hard to quantify. He notes that projects with participation as an objective might not follow a predictable path. It is difficult to know how this objective will manifest itself or what the likely outcome will be.

He gives the following reasons for using qualitative methods as tools for looking at the process. A qualitative evaluation has the following advantages for assessing a dynamic change rather than a static impact. They are naturalistic in that the evaluator does not attempt to manipulate the project for the purposes of the evaluation. The researcher describes what is happening in a project rather than assessing expected outcome. Qualitative evaluation is an evaluation which allows for the continuous redefinition of knowledge and project outcomes rather than being restricted to preformulated questions. Qualitative evaluation is holistic, allowing the project to be seen within the context of its environment and allowing the exploration of relationships between participants, activities and so on. It is based on inductive analysis in which the evaluator seeks to understand the process rather than imposing predetermined expectations. Finally, it implies a continuous and close contact with project participants in their own setting.
The search for process indicators based on qualitative methods has not been straightforward. As the word ‘indicator’ implies measurement, it is easily placed back in its quantitative framework. In addition, the term ‘indicator’ suggested that there is a universality about assessing the process. Qualitative inquiry, as Oakley (1990) describes it, is really about local not universal situations.

However, the challenge of seeking to assess participation has continued. In the health field for example, the work of Rifkin, Muller and Bichmann (1988) takes up that challenge and suggests the following framework for assessing participation. Starting from the definition of CP as a ‘social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet their needs’, Rifkin and colleagues define five factors which characterise the participation of the community in a community health programme: 1. needs assessment; 2. leadership; 3. organisation; 4. resource mobilisation; and 5. management. For each factor a continuum is developed, ranging from wide participation on one end to narrow on the other. Wide means the community is planning, implementing and evaluating the programme, with the professionals acting only as resources. Narrow indicates everything is done almost exclusively by the professionals, without any lay participation. Divided into five parts, the point which most closely describes the CP in the programme being assessed is marked. The points on the different continua.

Fig. 4. Descriptive ranking scale for the assessment of community participation

Source Rifkin, Muller and Bichman (1988)
are linked with each other thus producing a visualisation of the broadness of community participation (see Figure 4). In Nepal, Bichmann (1989) developed a descriptive ranking scale to facilitate the assessment.

This framework has been used by several programmes in both developed and developing countries. It has been used retrospectively to evaluate a community accident programme in Sweden (Bjaras, Haglund and Rifkin, 1991); a community-based health programme in the Philippines (Laleman and Anny, 1989); in Nepal (Bichmann, 1989). It has been used in Indonesia to assess participation in health promotion activities starting with the assessment at the beginning of the project and doing another assessment when it ended in two years (Nakamura and Siregar, 1996). It has also been used to introduce district level management teams into ways of assessing participation in Tanzania (Schmidt and Rifkin, 1996) as well as being proposed as the means by which to assess community participation in the Kellogg Foundation Community Health Partnership Programmes in South Africa (Kelly and Vlaenderen, 1995).

Stimulated by this approach, Engelkes (1990) attempted to expand the idea of process indicators in evaluating a PHC programme in Colombia. The process indicators included the collection of qualitative information and participatory evaluation in which programme beneficiaries did an evaluation of the programme. The indicators were useful for programme improvements and were defined in terms of the local situation. Although Engelkes speaks of ‘measuring the process’ in fact the paper presents a description of the situation and views based on interviews. It does not give numbers or measure anything. The tension between qualitative and quantitative analysis is explicit.

The strengths of seeking a process approach to evaluating participation are several. Firstly, the approach begins to overcome the problems of accepting presence as an indicator showing active participation. It seeks to articulate other ways by which thoughts, not mere actions, could be examined as part of the change process. Secondly it seeks to follow the dynamics of changes in programmes and people and to track these changes in a systematic way. By developing a framework for information collection, by using tools available to assess change and by approaching the evaluation with a protocol and methods of triangulation (discussed in Chapter 3) it helps to gain credibility for qualitative methods and the information they give about the change process. Thirdly, it provides frameworks for collecting and analysing qualitative information which gives depth rather than breadth to the understanding of community participation. The quality of information improves as does the interaction of the evaluator(s) with project participants.

The weakness of this approach is that indicators and evaluators are external to the community whose project is being evaluated. If the evaluation of the participation process is to be credible, it is argued by advocates of participatory action research (PAR) that those in the project must be actors not acted upon. In the health field, as
well as in other fields of social development, the case for participatory evaluation has been argued by contributors to the book by de Koning and Martin (1996). The theoretical aspects of this position, using the experiences of community partnerships in health programmes in poor areas of South Africa as an example, are presented by Kelly and Vlaenderen (1995). Though the recognition of this weakness is extensive, to date the solution has not been found in the widespread literature.

**Conclusion**

In this chapter we have reviewed the major theoretical constructs which examine the nature, value and preconceived use of community participation. We then described the attempts to translate these theories into practice by constructing analytical frameworks to give context for project developments. We described views about factors which influence participation as well as methods for evaluating participation. One theme which continues to run through the review is the theme of power and control and the question of need and the potential conflict of negotiating these aspects between planners and communities involved in projects. Having in these first chapters explored the nature of this tension, in Chapters 4 and 5 we look at the methods and tools and then at case studies which have been developed and applied to either address or avoid these aspects in project implementation.

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PARTICIPATORY APPROACHES IN HEALTH PROMOTION AND HEALTH PLANNING


4. APPLICATIONS, METHODS AND TOOLS

Summary

This chapter examines the applications, methods and tools which have been used to translate the theoretical constructs and conceptual frameworks described in Chapter 3 into project planning and implementation. We focus on those which are used to translate the people's participation and empowerment into practice. The first section investigates the two areas in the health field in which these constructs have most often been used according to the literature. These are the areas of participatory action research (PAR) and of rapid appraisals (RA). The second section briefly describes the methods drawn from qualitative inquiry which serve as the basis for most of the participatory approaches. The description provides the basis for the third section entitled 'Tools'. Here, we explore the more innovative contribution of the participatory approaches, emerging particularly from the RA applications, those of visualisations. The tools section describes the most popular visualisations emerging from experience in the rural development and health/nutrition fields. Appendix C contains a detailed description about how to use these tools, taken from the manual written for Save the Children by Theis and Grady (1991).

Applications

Translating the theoretical constructs and frameworks into actual use in the field has a varied history. PAR has a direct and explicit connection with participatory approaches because its foundations, theoretical and conceptual, are in the people's participation and empowerment constructs. This connection has enabled projects opting for the approach to translate the construct directly into action.

Rapid appraisals have a much more circuitous path. Much of the ground work was motivated by searching for rapid and reliable information, which could be applied fairly quickly to programme planning. This initial goal, through experience and translated into the literature by Chambers (1994a, 1994b, 1994c), began to emerge
with the participatory values derived from the people's participation and empowerment constructs. However, many planners particularly in the health field, enticed by means of quick and quality information, have continued to be concerned mainly about getting a product of good information rather than the process of participation. For this reason, the terminology has tended to be imprecise, prolific and confusing. For a glossary of terms see 'Terminology' below.

In addition, the umbrella term 'RA' is often used, particularly in the health sector in the United Kingdom, to denote any type of needs appraisal/assessment in which members of the geographic community have been consulted. Although it is often cited as a means of community participation, critics of this approach note that it is actually professionals extracting information from lay people and is not encompassing the empowerment aspect critical to participatory approaches.

**Participatory action research**

The history of participatory research (PR), or participatory action research (PAR) as it is also called, emerged from the theoretical constructs of people's participation and empowerment. Inspired by the latter, and in particular the educator Paolo Freire, its focus was to address problems of poverty and helplessness through linking research with empowering education and action. It is associated with the names of Fals-Borda in Latin America, Tandon in Asia and Hall in the area of adult education (Fals-Borda and Rahman, 1991; Tandon, 1996; Hall, 1975) whose experience in the developing world gave scope and shape to these ideas. Contributions to the theoretical underpinnings were made in feminist research in the 1980s (Maguire, 1987). She discussed how participatory action research, despite being more transformative and liberating than traditional research, continues to ignore the gender bias. She argued that male concerns continued to define the agenda and these agendas were biased against women's interest. Male hierarchies dominated the research and women continued to be marginalised despite PAR's commitment to liberation.

Participatory action research is research which involves all those concerned with the outcome in the entire research process from planning to evaluation. It focuses on the involvement of marginalised people who have traditionally been objects not subjects of research and sees as a major objective to empower them through this process. Hall (1975), a key promoter of this approach through his work with the International Council for Adult Education, identifies seven principles. Firstly he states that PAR is not neutral research as the scientific community often suggests but has an ideological dimension, a key element of the thinking of Freire (1972). Secondly he says research must have some immediate and direct benefit to the population involved and not become just an academic exercise for the researcher. Thirdly, the research needs to involve the designated population or community in the entire research process from formulation to interpretation of findings and decisions about...
resulting action. Fourthly, if the outcome of the process means that the research objective changes, the new approach must include representatives of those for whom this approach will have implications. Fifth, the research process needs to be seen as a holistic education experience serving community needs and increasing awareness and commitment within the community. Sixth, the process should be dialogical, developing over time and not be seen as giving a static picture at one point. Finally, 'the object of the research process, like the object of the educational process, should be the liberation of human creative potential and the mobilization of human resources for the solution to social problems' (Hall, 1975, p. 30).

Growing from the debate about the objectivity of social sciences and the sociology of knowledge in the early 1970s, PAR was given a boost when it was undertaken as a project area of the International Council of Adult Education in 1974–75. In the 1960s and 1970s, the intellectual framework was strengthened with the writings of Illich (1971) and Freire (1972) which linked the process of knowledge formation and education with its implications for social transformation. Contributions from Lewin concerning action research and the work in the 1980s concerning the expansion of knowledge beyond mere intellectual cognition contributed to the growing intellectual base (Tandon, 1996). The formulations of ideas around people's participation and empowerment and in practice through the work of people like Oakley and colleagues (1991) and Chambers (1997) cemented the relationship between the constructs.

The early work in PAR focused on the more intellectual construction of the concept particularly on epistemological explorations and the questions concerning the objectivity of research. The scientific rigour over research methods often focused on the qualitative/quantitative debate and the validity of contributions by those without research experience (non-experts). In the 1990s with a wide range of recorded experiences particularly around the work in participatory appraisals, the discussion has switched from centring on the legitimacy of the approach to the process.

Cornwall and Jewkes (1995) identify four issues, which have emerged in this context. The first is concerns about the attitudes and behaviours of the external researchers. Attitudes and behaviours are critical to establishing rapport and address the empowerment aspects of PAR. Researchers need to be facilitators not controllers. Chambers (1997) explores this issue further. He argues that methods that allow information exchange to be open, shift the dialogue from individuals to groups and build partnerships through the sharing of experiences, food and training are key to building attitudes and behaviour necessary for using participatory approaches. The second issue is whether the process of information collection is extractive or participatory. When researchers define the framework, do the interpretation and make decisions about action it puts severe limits on the participatory process. In this context, the question of ownership of information also emerges. It has been an area of struggle for those engaged in PR as sharing of the research process is not a common experience for many outside experts/professionals.
A third issue is how the process is to be sustained. Cornwall and Jewkes (1995) describe problems over sustaining commitment, interest and energy but do not explore this area in any depth. We examine this issue further in Chapter 6.

A final issue is the use of visualisations, which we will explore in more detail in the later part of this chapter.

The interest and importance of PAR has increased in the last few years. In the early 1990s, the Royal Society of Canada undertook a study on participatory research in health promotion in which it reviewed over 400 of these types of projects. The investigation produced a conceptual framework, which showed the relationship of the areas of public health research, public health practice and participation. Figure 5 illustrates areas of overlap of these three components in PAR.

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Fig. 5. Relationship of public health research, public health practice and participation

Source: George, Green and Daniel (1996)
In addition to the stated purpose of the project, guidelines were produced to help agencies assess the degree to which a proposed project met criteria of participatory research. Assessment questions were divided into six categories:

- who were the participants and what was the nature of their participation?
- what was the origin of the research question?
- what was the purpose of the research?
- what was the process and the content of the research and what were the methodological implications?
- what opportunities did the research provide to address the issue of interest?
- what was the nature of the research outcome?

The framework for this assessment with specific questions for each of the above categories is included as Appendix A.

Canadian support for PAR has given rise to a number of useful contributions to this field. For example, an article in *Health Promotion International* by Boutiller, Mason and Rootman (1997) examines the translation of participatory research in health promotion based on experience in two projects. They propose a model entitled community reflective action research (CRAR) which combines community collaboration with practice-based and participatory research. It seeks to improve the practice of health promoters in organisations and research whose purpose is community education and action. The model is the result of confronting practical dilemmas in community-based health promotion with demands of the research community. In practice, Boutiller and colleagues applied this method in two projects. Working with community residents, everyone kept journals reflecting on their work with the two project organisations. Thus, information was gathered from researchers, health promoters and community people. Reflections in the journal were shared among participants at meetings scheduled at various points in the research cycle. Learning from these insights was incorporated into the next project cycle. The result was that all project participants engaged in reflection and action and fully in the development of the project.

More concretely, Canadian researchers have proposed PAR as an approach to evaluating WHO’s Healthy Cities programme. In two articles published in *Health Promotion International* Poland (1996, 1997) puts forward the theoretical and conceptual arguments and suggests the appropriateness of the approach to the demands of evaluation of the programme. He identifies three principles as the basis of knowledge development and evaluation. The first principle is that it must adhere to the core tenets of participatory action research. The second is that it embodies a critical social science perspective meaning that the political nature, value base and contingent nature of the work must be recognised. The third is that it is derived from an understanding of how local people think about evaluation. The articles, however, do not specifically focus on participation and/or the poor but rather on the comprehensive evaluation of the whole programme.
Rapid appraisals

Rapid appraisals became popular almost at the same time, in the early 1980s in both the health and development fields. Their history helps to explain the diversity of terms, which are used under this umbrella. They all share the following characteristics:

- they are relatively quick and inexpensive to undertake when compared with longitudinal surveys.
- the main aim is to address the problems of communities, particularly poor communities, rather than individuals.
- the objective is to collect information for action rather than only documentation.
- they are still in the process of evolving tools and techniques to improve data collection and analysis. In other words, there is no set model for carrying out a rapid appraisal. (Rifkin, 1996)

Terminology

The terminology is described in terms of historical development and in the context of the field of health as this review focuses on participatory approaches in the health sector. However, as the description illustrates, the more participatory approaches come from an interface between health and rural development experiences in the developing world.

In the field of health, the RA approach started from the experiences in the United States. Concerned mainly with getting quick, quality information they appeared under the title of rapid assessments. These include (Rifkin, 1996):

*Rapid epidemiological assessment (REA)* based on the disciplines of epidemiology and statistics. Its purpose is to collect data relatively rapidly by using small area surveys and sampling, surveillance methods, screening and individual risk assessment and community indicators of risk or health status (Selwyn et al., 1989). It has been mainly used to evaluate how health services function where constraints on staff time are critical.

*Rapid assessment procedures (RAP)* is based in the discipline of medical anthropology. RAP uses the conventional anthropological methods of interviews, conversations, observation, participant observation and focus groups. The techniques are applied for the purpose of gaining information about people’s views and beliefs about health, the treatment and prevention of disease and the use of both traditional and modern health care. Based on the use of these methods in sixteen countries, a training manual was produced (Scrimshaw and Hurtado, 1987). It has been used in a range of countries and situations with a variety of results (Scrimshaw and Gleason, 1992).

Closely related to RAP in its use of anthropological techniques is *rapid ethnographic assessment* (Bentley et al., 1988). Emerging from the RAP experience, it uses these
techniques to collect data concerning people’s beliefs and practices in relation to a specific disease. Under the auspices of the World Health Organization (WHO), this approach has been supported in order to improve management of acute respiratory infections (Pelto and Gove, 1992). The use and value of rapid assessment procedures and rapid ethnographic assessment for health planners has been comprehensively reviewed by Manderson and Aaby (1992).

The term rapid appraisal, distinct from rapid assessments, described above, appeared in the health literature in the early 1980s (Melville, 1993). From the field of rural development, particularly farming systems, experiences suggested that an alternative approach to ‘top-down’ planning might be more appropriate in addressing the needs of the rural poor. In 1979 a group of academics and practitioners met to systematise these experiences. Under the title of rapid rural appraisal (RRA), a conceptual framework was put forward that gave form and substance to information collection, which did not rely on the traditional quantitative survey. The attraction of this approach to those in health programmes was not solely the possibility of rapid data collection. RRA emphasised priority setting for the poor and community participation, two of the major principles of primary health care. It also emphasised intersectoral, or in this case interdisciplinary, approaches using a number of people from different sectors and from different organisational levels. It differed from rapid assessment because in rapid appraisals: 1. the data collection and analysis were done by multidisciplinary teams rather than those from a single discipline; 2. community members were involved in both the information collection and analysis rather than serving as mere informants for data collection; 3. the appraisals were constructed in an iterative (repeating methods to gain new understanding and building upon that understanding) process context in order to improve planning rather than only as an information collection exercise.

With the support of WHO and with RRA as a basic framework Annett and Rifkin (World Health Organization, 1988; Annett and Rifkin, 1995) developed guidelines for a type of RA which sought to involve key community informants in the appraisal process not just as people to provide information but also as participants in data analysis and priority setting. The term rapid participatory appraisal (RPA) was used to distinguish this approach from the agricultural RRA and the evolving PRA.

RRA has expanded the concept and methodology to address issues outside the original rural data-gathering objectives. Experiences of practitioners mainly in India have focused on the development of participatory techniques, which involve including the informants as partners in the information planning process (Mascarenhas et al., 1991; Chambers, 1994a; 1994b; 1994c). This shift in emphasis was subsumed under the term, participatory rural appraisal (PRA) (Chambers, 1994a) or participatory rapid appraisal (Theis and Grady, 1991), highlighting the potential of RRA as a catalyst to a learning process and the contributions of adult education and psychology to the methodologies.
Most recently, practitioners and theorists involved in PRA are beginning to reject this term also. As the process which is described is not rapid, but long-term capacity building and nowadays used in urban as well as rural settings, they prefer the term participatory learning approaches (PLA). The International Institute for Environment and Development which publishes RRA Notes has now renamed the publication PLA Notes.

Development and use

We have described the history and terminology of RAs in the section above. In this section, we investigate the basis of RRA as its development has had a great influence both on the use of RAs in the UK and as the basis for the more participatory needs assessment under the title of PRA/PLA.

Rapid rural appraisal was put forward in the late 1970s by Robert Chambers and a group of colleagues at the Institute of Development Studies in Sussex (Chambers, 1981) with the purpose of improving the planning process in the field of agricultural and rural development. RRA sought to overcome the limitations presented by long surveys which came too late for use in decision-making and the biases of planners who often visited people in villages in dry seasons, along tarmac roads. Defined by adherents as ‘any systematic activity designed to draw inferences, conclusions, hypotheses, or assessments, including acquisition of new information, in a limited period of time’ (Beebe, 1987, p. 49), RRA was seen to give quick and accurate information for identification and appraisal of rural development problems in order to take action to solve these problems.

From the beginning, RRA practitioners from a wide range of disciplines and experiences were involved in sharing their ‘informal’ and less orthodox approaches. Interest in these experiences and the approach which was used, expanded fairly rapidly. While originally the methodology was used for initial appraisals of situations, it has now been used also for monitoring and evaluating projects.

RRA has been used as a means for planners to get quality information comparatively quickly on which to take action for development interventions. The approach has two essential characteristics. The first is that it is based on qualitative enquiry. For programme managers and planners in all fields, these qualitative methods have proved useful in practical problem-solving, action research and monitoring and evaluating programmes.

The second is the participation of programme beneficiaries in the information process. As we have earlier noted, it is seen as a principle of PHC and, therefore, is critical to health planning following this policy.

RRA and its evolution into PRA draws its conceptual framework from a number of fields including: agricultural economics, agro-ecosystems analysis, applied
Anthropology, rural and community development and adult education. As Chambers (1981) explains, RRA rests on two principles which ensure its methodological rigour but avoid unnecessary data collection. These principles are:

- optimal ignorance which demands that information which is not relevant to the objectives of the collection exercise must be ignored.
- proportionate accuracy, which demands that the accuracy of information be kept in proportion to its use and time not be ‘wasted’ in validating information which cannot be used.

The underlying philosophy of this approach is that data collection is valued as a process of learning in an iterative and systematic way in and of itself, not merely as an activity for the product of information.

The RRA approach is defined by a specific set of characteristics, which include:

- action-oriented research to be used by planners and managers for problem-solving
- community involvement in information collection and analysis
- emphasis on communication and listening skills
- holistic and systematic approaches
- multidisciplinary and interactive methods including visualisation of information to replace only verbal communication
- flexible responses to data collection and interpretation.

In this approach the process is Iterative Innovative, Interactive, Informal and In the field (Conway, undated).

Methods

While participatory approaches integrate quantitative and qualitative methods, they rely on qualitative methods. For this reason, we highlight two specific characteristics of qualitative research which are important specifically to participatory approaches. The first is its value for relying upon, and therefore promoting, interaction with people. The second is its value for supporting participation.

Concerning interaction with people, by its very nature, qualitative research is people-oriented research. Patton (1990) suggests that because it is people oriented, it has four distinct characteristics:

- the researcher needs to be involved in the research, getting close enough to people to understand what is going on.
- the researcher must capture what is actually taking place and what people perceive is happening.
Participatory Approaches in Health Promotion and Health Planning

- Qualitative data are descriptive, telling about activities, interactions and settings.
- Qualitative research reports must include direct quotations.

Concerning its value in supporting participation, qualitative research has additional characteristics. It:

- Seeks to solve a specific problem, which is to be defined by those who are affected by the problem and will benefit from the solution;
- Disseminates the information gathered through feedback in order to bring about a desired change;
- Attempts to generate a sense of ownership of the information by the beneficiaries in order to gain their support for the change programme;
- Recognises the key role of personalities in research information and outcomes and the political nature of research, thus demanding careful preparation to take account of these factors.

One question about qualitative methods in the context of health and the biomedical model is that of whether it is a sufficiently rigorous and systematic approach to investigation. Concerning rigour, two critical aspects distinguish qualitative from quantitative research in the context of data collection and use. The first is that it is cyclical and iterative, unlike quantitative research which might be described as progressive and linear (Hudelson, 1994). This aspect means that information collection is fed back into the research process and the process is then modified according to the information analysis. The research process is dynamic rather than static in a state of possible change, a characteristic that describes action research. The second aspect is that rigour does not rest in the rigour of natural scientific inquiry but rather in external validity and its description of uniqueness of situations.

The rigour and systematic approach is underpinned by triangulation. Triangulation rests on:

- Methodological triangulation where multiple methods are used to study a single problem/programme, that is qualitative and quantitative or two or more qualitative methods;
- Data triangulation where different data are used, that is interviews, observations and documents;
- Theory triangulation where different perspectives are used to interpret a single set of data;
- Investigator triangulation where several different researchers investigate the same phenomenon (Patton, 1990, based on Denzin, 1978).

People involved in health projects will use the first two types most often.

Triangulation, however, does not in itself eliminate the possibility of bias. Bias is possible both in the way in which interviewing is undertaken, observations are
made and data are interpreted. The only assurance that bias is kept to the minimum is through careful training in using the methods described below and in practice and experience. Qualitative inquiry requires awareness of possible bias and repeated concern for scientific rigour at all stages. One insurance is that data are read by those who have not been involved in the collection process to see if bias can be detected in the questions and/or in the data interpretation.

In Appendix B we briefly describe the core methods for qualitative inquiry. Methods of interviews and observations are based on a document prepared by Hudelson (1994) for the World Health Organization.

Tools

Introduction to visualisations

Visualisations are a means of moving the information process from oral to visual transmission. The development of visualisations owes much to the work of Freire (1972) which has been discussed above. In the framework of participatory approaches, the emphasis has been placed on enabling people without strong oral and/or written skills to have the opportunity both to develop these skills (Archer and Cottingham, 1996) and to contribute to the planning dialogue without these skills (UNICEF, 1993). Using maps, matrices and drawings breaks the monopoly of professionals whose power is often built on words. It allows those who lack oral and writing skills to contribute to both information and analysis. In this way, it brings into focus the importance of the power and control of the research process as the expert no longer holds the monopoly on the research methods.

Visualisations are certainly the most innovative contribution of this research. We suggest that experiences have provided both improved quality of information and an important dimension to the process of participation.

In the next section, we describe the most popular and probably the most used tools for visualising information. Under each umbrella heading we briefly examine a number of tools and cite some example of where they have been used in the health field. In Appendix C, we reproduce from Theis and Grady (1991) the instructions for using each of the tools that we describe. The final description is of an approach based on visualisation tools, mainly of diagrams and matrices, entitled Visualisation in participatory programmes (VIPP). We have included it because it is an approach which relies on visualisations to actively promote the aims and goals of empowerment and people's participation.
Mapping

Conceptual mapping is perhaps the most popular of the visualisation tools and is often used to begin a participatory appraisal. The exercise asks community people to draw their immediate surroundings and afterwards to explore the importance of various drawings with professionals and other community members. Maps are not reproductions of the area. In other words, they are not a drawing by which one could locate a certain address. Rather, they are conceptualisations of how community people interpret their surroundings. Maps are made using local materials – pens and paper – or lacking these, maps are drawn on the ground with sticks and use stones, leaves, packing materials, etc. to reproduce the area. Maps can show spatial relationships, locate potential resources, explain how things work, analyse change over an area over time and monitor changes as a result of an intervention over time (Rifkin, 1996).

There are increasing examples of the use of mapping in health and nutrition programmes (Pretty, 1992). They have been used to locate facilities and water supplies in the community, identify households with ill or ‘at-risk’ people and often as an entry point to begin an intervention programme. An innovative example is that of ‘body mapping’ which Cornwall carried out among women in rural Zimbabwe. Cornwall (1992) asked groups of women to draw maps on the ground to illustrate their understanding of reproduction. These maps became the basis for a process of explaining and exchanging views about sex and birth. In information shared among the women, it became apparent that understanding of this process had notable points of departure from scientifically-based descriptions and thus influenced the women’s views about use of contraceptive methods.

Another type of map, or perhaps better explained as a mapping exercise, and closely related to drawing the surroundings is transect analysis. In this exercise, outsiders and community people walk through an area, often the one which they have just drawn, to observe and discuss various areas of importance identified by community members. The term transect describes both the way information is gathered and how it is analysed. All participants walk through the area, and generate information about concerns, problems and/or possible solutions. The information is then reproduced to accommodate the information gathered. In the field of health, the tool has been used by Almedom and colleagues (1997) to describe its use in some detail (calling it a health walk) with the purpose of identifying hygiene practices and behaviour in relation to water and sanitation.

Seasonal calendars are another popular tool in which participants are asked to map specific developments over a period of time. ‘Seasonal’ suggests this period is over the year. However, the same tool is used to map developments over a shorter period of time, such as a day, and thus, it is often called a daily routine illustration. Both have the same purpose of investigating change over time. Seasonal calendars have been used to investigate amount of rainfall, food consumption, labour utilisation,
Village in Upper Egypt

Fig. 6. Example of a map

Source: Theis and Grady (1991)
**Fig. 7. Example of a transect**

*Source* Theis and Grady (1991)
Fig. 8. Example of a seasonal calendar
Source Theis and Grady (1991)
Fig. 9. Example of daily routine diagrams

Source: Theis and Grady (1991)
price changes and the relationship of these and other factors to each other. Such
illustrations often mean more to local residents than printed government reports
(Mascarenhas et al., 1991). In the health field in Uganda, for example, seasonal
calendars were used to map the prevalence of disease during certain months. This
visualisation led to a discussion about sexually transmitted diseases and the
relationship of the harvest (and thus more pocket money) to sexual activities
(Ssembatya et al., 1995).

A daily routine map similarly shows what events and/or activities take place in a
routine fashion over the day. It allows participants to identify time of much activity
and of leisure. It also allows, when made on a gender comparison, to see which
gender has more work and for what time periods. Such mapping has proved useful,
for example, to schedule clinics and health education activities.

**Ranking and matrices**

*Ranking* is a tool to enable planners to involve community people in setting priorities.
Like the other tools, it is most often used in conjunction with interviews to identify
community perceptions and generate information. It is also useful to deal with
sensitive information. *Direct matrix ranking* enables the group to identify a list of
criteria for a topic, then to understand preference for the list of items identified by
this topic. The matrix lists the topic items in one row along the top of the matrix
and the criteria for choice between items down the side of the matrix. Choices are
added to see which is the most important. One of the most well-known tools,
*wealth ranking*, for example, allows the investigator to explore the patterns of
economic disparities by asking individuals to identify proxy indicators of wealth in
their communities and then asking them to identify households which exhibit these
indicators (Pretty, 1989). Variations of ranking methods include: 1. *preference
ranking* where community people are asked to brainstorm to identify the topics to
be discussed and then asked to rank them in order of priority of concern; and 2.
*pairwise ranking* which is useful when too many topics for discussion are identified
and choices have to be made of which are priorities for discussion. The ranking
tool has been used to identify groups to be targeted for interventions. It has also
been applied to comparing choices of strategies for specific problems and to
prioritising solutions to specific problems. In the field of health Welbourn (1992)
has applied it to relate socioeconomic status to disease problems to see if there is a
relationship between disease and wealth. In Bangladesh poor women were asked to
rank priorities, giving high ranking to economic concerns and low to those of
health and illness. In Malawi, where socioeconomic groups were mixed at a
meeting to set community priorities, those who identified a health clinic as a
priority were those most vocal at the meeting and those who came from a higher
economic group.

A matrix which has been used for ranking priority interventions is the ‘best-bets’
matrix. This type of matrix lists alternative development strategies, which are
analysed according to the possibilities for successful implementation. In the health field, matrices have had wide-ranging applications. A best-bets matrix was used in the rapid appraisal undertaken with WHO in Mbeya, Tanzania (Annett and Rifkin, 1995) to identify which intervention suggested by the community the municipal council might most successfully undertake. Out of three suggested interventions – road improvements, providing each house with a latrine and improved refuse collection – the latter was the one which best met the criteria identified by the matrix. It has also been used for identifying the most prevalent disease problems in a poor Indian village (Francis, Devavaram and Erskin, 1992).

![Tree species matrix](image)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Eucalyptus</th>
<th>Palm</th>
<th>Acacia</th>
<th>Pine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fuelwood</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Building</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fruit</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Medicine</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Fodder</td>
<td>3</td>
<td></td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Shade</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Charcoal</td>
<td>2</td>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Total score</td>
<td>22</td>
<td>10</td>
<td>17</td>
<td>19</td>
</tr>
</tbody>
</table>

Rank
A
D
C
B

If you could plant only one species, which tree would you choose? Eucalyptus

4 = best 1 = worst

Repeat for a number of interviewees.

**Fig. 10. Example of direct matrix ranking**

*Source* Theis and Grady (1991)

![Constraints to agricultural production matrix](image)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Respondents</th>
<th>Total score</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drought</td>
<td>A B C D E F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pests</td>
<td>4 3 5 4 5 4</td>
<td>25</td>
<td>b</td>
</tr>
<tr>
<td>Weeds</td>
<td>3 4 4 1 3 3</td>
<td>18</td>
<td>c</td>
</tr>
<tr>
<td>Costs of inputs</td>
<td>2 1 2 2 2 2</td>
<td>11</td>
<td>d</td>
</tr>
<tr>
<td>Labour shortage</td>
<td>1 2 1 3 1 1</td>
<td>9</td>
<td>e</td>
</tr>
</tbody>
</table>

5 = most important 1 = least important

**Fig. 11. Example of preference ranking**

*Source* Theis and Grady (1991)
Fig. 12. Example of pairwise ranking matrix

Source Thes and Grady (1991)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Health benefit</th>
<th>Capacity for self-help/ participation</th>
<th>Sustainability</th>
<th>Equitability</th>
<th>Cost</th>
<th>Time for benefit</th>
<th>Feasibility score</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Every house to have a latrine built by the family</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>*</td>
<td>*</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>2 Provision of road</td>
<td>***</td>
<td>***</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>3 Construct refuse bays and garbage collection</td>
<td>***</td>
<td>***</td>
<td>*</td>
<td>***</td>
<td>*</td>
<td>***</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Fig. 13. Results of workshop ranking

Source Annetl and Rifkin, 1995

Diagrams

Diagrams are simple schematic devices to present information in a condensed and visual form. It may be considered a simplified model of the participants’ reality. In participatory appraisals, they are often used to summarise data to be used at all stages of the planning process. They are particularly useful in identifying problems or opportunities in specific areas, time periods, activities and in clarifying issues with participants and among members of the planning team.
Flow diagrams show causes, effects and relationships among key variables. For an example relating to investigating economic and environmental change in Sudan see Figure 14. In health, a variation of this diagram is a causal diagram in which causes and effects of a specific problem are drawn to show the relationship between the problem, the cause and effect. They have been used to look at the causes of disease at various times of the year and the causes of child mortality (Pretty, 1992).

Economic and environmental change in Central Kordofan, Sudan

Low producer prices
Population increase
High prices for consumer items

Increase in consumption + Cash needs

Increased wood cutting
Increase in cultivated area
Reduction of fallow periods
Increased livestock production

Decreasing rainfall

Decreased soil fertility
Decrease in crop yields
Environmental degradation

Off-farm activities
Out-migration

Fig. 14. Example of a flow diagram
Source: Thiers and Grady (1991)

Venn diagrams illustrate the relationships between key institutions and individuals in a community and their relationships and importance in decision-making. They help visualise the important people and organisations for decision-making; show the
overlap between these key institutions/individuals; and compare different people’s perceptions of the relationships. Examples in health include looking at the relationship of the local clinic to people’s health needs; the control of water in the village (Theis and Grady, 1991). They also have been used to evaluate training workshops in women’s reproductive health and other subjects (Francis, Devavaram and Erskin, 1992).

Fig. 15. Example of a Venn diagram
Source Theis and Grady (1991)
The tools described above are those which are the more conventional, and probably most often used. However, in the field of participatory approaches, these tools are continually developing. One strength of the visualisation tools is that they are flexible and are able to respond to individuals’ situations. Because they reflect the reality of those who are using them, they bring new insights and new ideas for their use in project planning.

**Information pyramid**

Many of the UK rapid appraisals rely on the visualisation of an information pyramid (Figure 16). This visualisation was developed in the context of rapid appraisals supported by the World Health Organization (1988) discussed above in section 3 ‘Rapid appraisals’ under ‘Terminology’. For defining and analysing the information it served two purposes. Firstly, the pyramid helped researchers to visually assess the amount of information necessary for the planning process based on primary health care. It suggested rather than collecting vast amounts of information about health services and disease patterns that more information was needed about community composition, structure and capacity. Visually, if the amount of information in any one block was disproportional to the others, then the pyramid would fall on its side. Secondly, by visualising ‘information blocks’ as categories for information collection and analysis an analytical framework was provided for the appraisal exercise. This model has been used in a number of planning exercises both in the classroom and the field.

![Information pyramid diagram](image)

**Fig. 16. Information pyramid**

*Source* Annett and Rifkin (1995)
Visualisation in participatory programmes

One approach for project planning has developed visualisations to promote participation and empowerment by using some of the tools, which have been described above. For this reason, it is worth describing in some detail.

Visualisation in participatory programmes (VIPP) emerged from experience of planning in adult education and owes its antecedents to Paolo Freire and other contributors to participatory action research. It also owes much support to the Metaplan techniques developed in Germany and introduced by the German government and NGOs through their aid programmes and their planning processes known as ZOPP (goal- (Ziel in German) oriented project planning) (UNICEF, 1993). Essentially, VIPP uses visualisation techniques to gain active participation of all those who are invited to planning meetings. In development project meetings, at present, this most often includes programme beneficiaries who have neither the skills nor credentials of the programme managers. VIPP is designed in part to overcome the reluctance of the latter to get involved in an active way in the planning process. It is also designed to build a consensus for decisions and responsibility about how projects should be planned and implemented.

Essentially, each meeting participant is given marker pens and pieces of card on which to write clearly and using key words to contribute ideas to the discussion. A neutral facilitator (a person not seen to be connected with the project in any way) collects these cards and then presents each to the entire meeting. The idea is discussed and a consensual decision is made as to where to place the card on a board, which is used to analyse the problem and reach a solution to that problem. These cards are placed in matrices and/or diagrams which help refine all aspects of project planning. They visualise both the process and the agreed upon end product.

A participatory atmosphere is created because no participant need be identified with the card he/she wrote, eliminating fear of repercussions from other participants. In addition, because the card, not skills in verbal fluency or experience in meetings, is the criterion for contribution, equalisation for participation is promoted.

VIPP, like PAR, has its roots in the empowerment construct. For this reason, it has been seen as an approach to democratise the planning process and help build the capacity of those who have not so far been included in these discussions. In the translation of VIPP into practice weaknesses do remain. One certainly is that literacy is necessary to any participation and often those who are the poorest and most marginalised have very few and/or very poor literacy skills. A second is that, despite mechanisms to prevent manipulation by professionals of the planning process, much anecdotal evidence suggests that manipulation does take place. Particularly, when planning is being done by a donor-identified project, professionals use their skill to gain consensus about accountability and responsibility that all too often reflects donors' needs, not those of the beneficiaries.
Conclusion

Applications and tools based on the methods of qualitative inquiry for participatory approaches have greatly expanded over the last two decades. They have contributed some of the most innovative and exciting aspects to participatory action research focusing on issues of empowerment through the education process. They have enabled project planners and managers both to gain new insights into views of local people and to find ways of involving these people at a deeper level in the planning and implementation process. Their use and value, however, reflects the objectives of the users. A rapid appraisal undertaking a mapping exercise does not, in itself, make the exercise participatory. Whether it is or not depends on the attitudes and behaviours as well as the objectives of project planners and managers. It can be argued that the methods and tools might be necessary for participatory approaches, but they are not sufficient to ensure participation in the constructs of people's participation and empowerment.

References


5. EXAMPLES OF APPLICATIONS FROM CASE STUDIES

Summary

Here we review experiences of projects which have either explicitly or tacitly sought participatory objectives in the people's participation and empowerment constructs. We examine the processes they follow in trying to achieve these goals and how it reflects the main issues identified in Chapter 2: Who defines the community? Is participation a means or end? Who decides on priorities and action? We analyse them in the framework of action research developed by Hart and Bond (1995). The examples which have been chosen to give substance to these issues are not necessarily the best examples but they do show how these issues have been handled within the framework and context of a specific project. For each stage which we define below we have chosen at least one example of where the visualisation tools have been used to promote participation. We have done so both to illustrate their applications in health programmes and to highlight their potential use and limitations in pursuing participatory approaches. In addition, we have selected a mix of studies from the developed and developing world in order to highlight the relevance in both settings despite the fact that most of the early development came from developing country experiences. It is critical to note that the case studies were described at specific stages of their development. Those presented are in the published literature. We reviewed the grey literature for case studies from the UK. The conclusion reviews what we found and suggests a way forward to access this literature.

Framework for analysis

Throughout this report we have considered the consequences of viewing participation of either a product or process. We have given examples to suggest it is better interpreted as a process responding to an environment and/or events which promote its development. A framework which helps to analyse the various stages of this process has been developed by Hart and Bond (1995) as a typology for action research. They draw a continuum with experimental action research based on the consensual model of society and on rational social management at one end and empowering action research which is based on the conflict model of society and on
structural change at the other end. In between there is the organisational type which is closer to the experimental and the professionalising closer to the empowerment. The continuum with the defining characteristics of each type of research is shown in Table 8.

### Table 8. Typology of action research

<table>
<thead>
<tr>
<th>Action research type</th>
<th>Rational social management</th>
<th>Professionalising</th>
<th>Structural change</th>
<th>Empowering</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consensus model of society</td>
<td>Conflict model of society</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distinguishing criteria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Educative base</td>
<td>Re-education</td>
<td>Re-education/training</td>
<td>Reflective practice</td>
<td>Consciousness-raising</td>
</tr>
<tr>
<td></td>
<td>Enhancing social science/ administrative control and social change towards consensus</td>
<td>Enhancing managerial control and organisational change towards consensus</td>
<td>Enhancing professional control and individual's ability to control work situation</td>
<td>Enhancing user control and shifting balance of power, structural change towards pluralism</td>
</tr>
<tr>
<td></td>
<td>Inferring relationship between behaviour and output; identifying causal factors in group dynamics</td>
<td>Overcoming resistance to change/restructuring balance of power between managers and workers</td>
<td>Empowering professional groups, advocacy on behalf of patients/clients</td>
<td>Empowering oppressed groups</td>
</tr>
<tr>
<td></td>
<td>Social scientific bias/researcher focused</td>
<td>Managerial bias/ client focused</td>
<td>Practitioner focused</td>
<td>User/practitioner focused</td>
</tr>
<tr>
<td>2 Individuals in groups</td>
<td>Closed group, controlled, selection made by researcher for purposes of measurement/ inferring relationship between cause and effect</td>
<td>Work groups and/or mixed groups of managers and workers</td>
<td>Professional(s) and/or (interdisciplinary) professional group/negotiated team boundaries</td>
<td>Fluid groupings, self-selecting or natural boundary or open/closed by negotiation</td>
</tr>
<tr>
<td></td>
<td>Fixed membership</td>
<td>Selected membership</td>
<td>Shifting membership</td>
<td>Fluid membership</td>
</tr>
<tr>
<td>3 Problem focus</td>
<td>Problem emerges from the interaction of social science theory and social problems</td>
<td>Problem defined by most powerful group, some negotiation with workers</td>
<td>Problem defined by professional group; some negotiation with users</td>
<td>Emerging and negotiated definition of problem by less powerful group(s)</td>
</tr>
<tr>
<td></td>
<td>Problem relevant for social science/ management interests</td>
<td>Problem relevant for management/social science interests</td>
<td>Problem emerges from professional practice/experience</td>
<td>Problem emerges from members' practice/experience</td>
</tr>
<tr>
<td></td>
<td>Success defined in terms of social science</td>
<td>Success defined by sponsors</td>
<td>Contested professionally determined definitions of success</td>
<td>Competing definitions of success accepted and expected</td>
</tr>
</tbody>
</table>

*continued opposite*
<table>
<thead>
<tr>
<th>Action research type</th>
<th>Experimental</th>
<th>Organisational</th>
<th>Professionalising</th>
<th>Empowering</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distinguishing criteria</strong></td>
<td>Social science, experimental intervention to test theory and/or generate theory</td>
<td>Top-down directed change towards predetermined aims</td>
<td>Professionally led, predefined, process-led</td>
<td>Bottom-up, undetermined, process-led</td>
</tr>
<tr>
<td><strong>4 Change intervention</strong></td>
<td>Problem to be solved in terms of research aims</td>
<td>Problem to be solved in terms of management aims</td>
<td>Problem to be resolved in the interests of research-based practice and professionalisation</td>
<td>Problem to be explored as part of process of change, developing an understanding of meanings of issues in terms of problem and solution</td>
</tr>
<tr>
<td><strong>5 Improvement and involvement</strong></td>
<td>Towards controlled outcome and consensual definition of improvement</td>
<td>Towards tangible outcome and consensual definition of improvement</td>
<td>Towards improvement in practice defined by professionals and on behalf of users</td>
<td>Towards negotiated outcomes and pluralist definitions of improvement account taken of vested interests</td>
</tr>
<tr>
<td><strong>6 Cyclic processes</strong></td>
<td>Action and research components in tension, action dominated</td>
<td>Research and action components in tension; research dominated</td>
<td>Identifies causal processes that are specific to problem context and/or can be generalised</td>
<td>Change course of events, recognition of multiple influences upon change</td>
</tr>
<tr>
<td></td>
<td>Identifies causal processes that can be generalised</td>
<td>Identifies causal processes that are specific to problem and/or can be generalised</td>
<td>Spiral of cycles, opportunistic, dynamic</td>
<td>Open-ended, process-driven</td>
</tr>
<tr>
<td></td>
<td>Time limited, task focused</td>
<td>Discrete cycle, rationalist, sequential</td>
<td>Spiral of cycles, opportunistic, dynamic</td>
<td>Open-ended, process-driven</td>
</tr>
</tbody>
</table>

Source: Hart and Bond (1995)

It may be argued that health projects with participatory approaches are essentially action research projects. If we understand research to be a systematic approach to
the study of specific phenomena, then all these projects share the characteristics described by Hart and Bond (1995), see section 5 ‘Action research’ in Chapter 3. Using their continuum to examine case studies will enable us to explore the stage of development at which they are and the processes important to this stage.

Typologies of action research

Examples of experimental action research

Projects at this stage of participatory development, despite verbal commitment to empowerment and shift in power structures, can often be confined by historical and institutional barriers. This situation is the case with health projects where empowerment goals are recognised as key to the project but the process is slow due to professional stakes and community expectations of a health service. It may be argued that these projects still have roots in the community development construct because project planners tend to look at communities as homogeneous geographic entities approached by seeking consensus and rational social management. The following case study designed to address the growing problem of AIDS in Uganda under the auspices of the Medical Research Council is an example of this type of project and of the type of action research entitled experimental.

The Medical Research Council Research Programme on AIDS in Uganda sought to create community involvement in the research process and specifically in the identification of the problem and its prevention (Seely, Kengeya-Kayondo and Mulder, 1992). This programme was established by the British government at the request of the Ugandan government. Its overall aims were to study the dynamics of HIV-1 transmission, the natural history of HIV-associated disease and strategies for AIDS control in a rural population. The whole population of fifteen villages in one rural sub-district were recruited into a cohort to be followed up for a period of at least five years. The study location was selected in 1988 by officials from the Ugandan government, the MRC and the relevant district health authorities. This region is heterogeneous in terms of political structure, ethnic composition, religion, although there is less variation in relation to occupation (primarily subsistence agriculture or cash cropping).

Efforts to achieve community involvement consisted initially of contacting local political leaders, who assisted in recruiting local staff and finding accommodation. One of these became an employee on the programme (the community liaison officer). This initial step was followed by a mobilisation campaign in 1989 to inform people about the programme, by holding a series of village meetings in which the villagers were addressed by programme staff, including the community liaison officer. During phase 1 of the research project (collection of baseline data) local people were employed to conduct a household mapping survey, as interviewers and as field office staff. The interviewers also acted as intermediaries between the
programme and local communities. As difficulties arose in gaining people's participation in the study, some of the interviewers became full-time mobilisers.

From late in 1989 other initiatives to create community participation were implemented. These included community counselling to provide information about HIV/AIDS for which seven local people were trained as counsellors. Others became voluntary community HIV/AIDS information personnel working in their own villages. Some of these formed a teachers' working committee, which started various village-level activities, such as song and drama concerts with health education messages. At the instigation of local leaders a football and netball tournament was established and at the request of local women a women's group was formed to provide a forum for them to learn about HIV/AIDS. This group later developed into a forum for discussion about ways of preventing the spread of HIV. A local health advisory committee was also established at the request of local community leaders to be involved in discussions on programme policy. This committee had an informal advisory capacity and was also a means of disseminating information about programme activities.

The authors, in analysing the process described above, used a typology of four levels of participation – contract, consultative, collaborative, collegiate – derived from the agricultural research literature. They concluded that the type of participation in this project was primarily of the contract nature in that the consent of people to take part in the research was gained and also some local people were actually employed on the study. Some efforts were also made to achieve a consultative level participation via meetings with villages and village leaders, but this did not extend to participation in any decision-making processes. Collaborative participation was minimal (one local women was a key collaborator in a study of sexual behaviour) and there was no collegiate-level participation. In addition the participation in this study was selective, with the exclusion of those who were less powerful. The programme had a divisive effect upon the population with any benefits unequally distributed and the subsequent creation of envy and exacerbation of existing divisions. Also the community and all research questions were both defined by outsiders.

This case study is of experimental action research with time-bound outputs and goals. The researchers defined the community geographically, defined the research question and, based on the community development construct, defined how people should participate – mainly through mobilisation in activities identified by the project planners. It focuses on a question which underlies much of the work in participation in project planning – how can a project seeking to be defined in the empowerment construct pursue these objectives when outside planners/professionals decide upon the community problem and often the solution?

The tools of visualisation have provided a means by which project planners and managers can introduce participatory approaches into projects. As we have
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suggested, they have often been used in the appraisal stage, stimulating community members to become partners in the information process. However, as PRA/PLA advocates argue, it is not the tools themselves but the process by which they are used which decides whether the project promotes or inhibits wide participation. The following case study illustrates how, at the present stage of development, a project in the Bombay slum used the visualisation more as an extractive process to get information than an empowering process to build local capacity.

A study conducted in a Bombay slum (Budh Mandir) (Emmel and O'Keefe, 1996) used visualisation methods to explore both lay and professional perceptions of health-care needs with the purpose of defining appropriate health-care delivery. Existing health care in the slum was mostly provided by private practitioners working in the larger slum area. In addition a local NGO funded and ran a mother and child health (MCH) facility. Community health workers (CHWs) were attached to this facility and provided health education and treatment for minor illness and ran monthly meetings to create local involvement in the MCH project. The investigators were ex-patriot academics from the UK.

Six meetings were held with local women over a period of one month. These were facilitated by a CHW who also acted as interpreter. Between six and eight women attended each meeting. In addition, informal interviews were held with key informants from Budh Mandir and the MCH facility and the information from these was used to plan the first meeting. Subsequent meetings were planned via SWOT (strengths, weaknesses, opportunities and threats) analyses. Triangulation of data was carried out via cross-checking at other meetings and with data from key informants. The visualisation methods used were health ranking, mapping and seasonal mapping. The health ranking was used with three groups: a doctor and social worker employed at the MCH facility; three CHWs also working at the MCH facility; and eight women living in Budh Mandir. The other two methods were used at the meetings with the women.

The health ranking exercise revealed differences in the perceptions of health needs between all three groups. There was reasonable consonance between the ranking of health problems by the community health workers and the local women, but not between either of these groups and the health professionals. Both of the former groups identified alcoholism as the greatest health problem, which the doctor and social worker saw as a social rather than health problem. One result was that this information was used to modify the focus of the monthly women's groups held at the MCH clinic by training the CHWs in participatory methods and to modify the clinic's health education programme. Another result was that the health professionals acknowledged alcoholism as a major problem and the need to develop ways to deal with it.

In this study the researchers defined the community and the research questions. The research tools were used to gather information in an extractive manner in that
participants were not involved in subsequent decision-making processes for which the information was gathered, that is the provision of appropriate health delivery to the community. So, despite a stated objective of empowerment, we argue that this project falls within experimental research as characterised by Hart and Bond. This study illustrates that the use of tools coming from participatory approaches does not make the project participatory. To be participatory information must support a process of creating opportunities for the poor and marginalised to gain skills and experience to shift some of the power and control of the project. It also needs to define mechanisms to continue the participatory process beyond the data collection stage.

Examples of organisational action research

This type of action research might be used to describe many of the projects in which health authorities seek to generate participation among the geographic communities for which they are responsible. Planners/professionals wish to include community perceptions about problems in their analysis but essentially it remains their analysis. Although people who choose to use RAs of this type do seek to involve non-professional community members in data collection, and analysis and responsibility for follow-up action, the managers continue to hold resources and decide how resources will be allocated. Many of the early rapid appraisals, in developing countries and adapted in the UK, can be seen to fall into this type. As Bond and Hart describe, this type often sees problems to be dealt with within management aims and solutions are sought in terms of consensus. The collaboration is clearly marked as consultant–participant with clearly differentiated roles.

One of the earliest applications of the RRA techniques to health projects was undertaken in Benin in the mid-1980s. It was jointly undertaken by the Centre Régional pour le Développement et la Santé/PDS Pahou (Benin) and the Royal Tropical Institute, Amsterdam in 1985/86 (Varkevisser, Alihonou and Inoussa, 1993). The purpose of the project was to identify interventions to improve the health and nutrition of mothers and children in three zones in South Benin. Initial information collection combined both qualitative and quantitative methods, using the former to get mothers’ views about causes of malnutrition and the latter for describing the magnitude of the problem. Multi-disciplinary teams together with community people developed an analytical framework and the data collection techniques, then undertook the data collection and analysis together. A feedback exercise was done to inform the villagers about the results of the study. The information gathered was the basis for the programme. The information was cross-checked by an extensive epidemiological socioeconomic and nutritional survey, carried out shortly afterwards.

Relying on qualitative methods for both conceptual development of the appraisals themselves and on the process of data collection and analysis, this approach was
used in all three study areas (Varkevisser, Alihonou and Inoussa, 1993). Their publication illustrates the advantages of these methods. One advantage was that the multi-disciplinary composition of research teams which included local health and other staff in these zones enabled a realistic appraisal both in terms of information sought and logistics to be undertaken. In addition, the involvement of key informants at the village level for information and when possible for interpretation and analysis gave greater validity to the research. It was found that key informant identification through wealth ranking helped the research team to identify members of low-income groups and to identify a useful entry point for discussion about causes of malnutrition (Varkevisser, Alihonou and Inoussa, 1993, p. 87). An additional advantage was that the service providers in health, agriculture and social services who had carried out the RRAs together could act upon the recommendations which grew out of their experiences in the study in their daily activities.

However, the experience did highlight some of the constraints of using RRA. A major constraint was the problem of estimating a realistic time frame to complete the exercise. It took a comparatively long time for the research objectives to be clearly identified and articulated (Varkevisser, Alihonou and Inoussa, 1993, p. 85), in part because the research team had different disciplines and thus a common language and approach needed to be created. A long period was also necessary to get administrative procedures with representatives of different sectors completed in the field to undertake the work. Another constraint was the lack of training of some of those involved. Although they were good interviewers, local level staff had problems in recording and analysing the information they had collected. This experience suggested that a good mix of more and less experienced researchers was required to carry out this type of work.

By the late 1980s RRA techniques were developed to be used for needs assessments in the urban, rather than rural, areas. In the health field, the World Health Organization supported such efforts by using consultants to write and then test guidelines for rapid appraisals in urban areas of Africa, notably Tanzania. A 10-day workshop was conducted to train multi-disciplinary teams to undertake the appraisal with key informants in the community. The workshop consisted of identifying information needed, the people who might best give information, and the types of observations and secondary data necessary to triangulate information from interviews. After teams collected and analysed the data they returned to the interviewees to confirm information and to ask these informants to prioritise problems the analysis had identified. The strengths of this approach included: teams gaining familiarity with problems they could not identify by sitting in their offices; experiences of working in multi-disciplinary teams and identification of the value of community involvement in information collection and action. The weaknesses included the lack of training to undertake the appraisal in order to offset bias in choosing informants and doing interviews; and the lack of time to complete the exercise properly (Rifkin and Annett, 1991).
One result of this initiative was the publication of a manual to enable municipal officers to make appraisals of health problems in the wider socioeconomic context of poor urban areas (World Health Organization, 1988). Pilot-tested in Tanzania, the guidelines became the basis for conducting rapid appraisals in Bangladesh, Bolivia and several other projects including those of the local health authorities in the United Kingdom (Cresswell, 1996; Ong et al., 1991; Ong and Humphris, 1994). The main objectives of these appraisals were to identify community problems which could later be investigated using quantitative methods and to engage the community leaders in the process of prioritising problems and seeking solutions. These guidelines, based on these experiences and taking up the challenges presented by developments in PRA/PLA were revised in 1995 (Annett and Rifkin, 1995). To distinguish these guidelines from other types of rapid appraisals the term rapid participatory appraisal (RPA) was used.

The South Sefton health authorities in Merseyside were the first to use rapid appraisal based on the WHO guidelines (World Health Organization, 1988) as a contribution to a revamping of health services due to managerial changes in the county (Ong et al., 1991). With priorities placed on decentralisation and community involvement, an RPA was carried out by multi-disciplinary teams to assess community needs in one of the poorer districts under this health authority. Undertaken over a 5-month period, the team doing the appraisal still recognised it was rapid compared with other community research which had been previously done (Ong et al., 1991, p. 913). The findings were integrated with quantitative data which had already been collected to provide in-depth baseline information about community needs and resources. For the managers, the benefits included: flexibility of the methodology; its potential of providing a strong link between community and health managers; its potential to help planners identify problems of community but not necessarily professional concern and its potential of multisectoral involvement for resource contribution and management. In addition, mechanisms were established for managerial accountability to the community. Identification of limitations focused once again on developing a realistic time frame under which to do the exercise and acquiring the skills to interview and interpret data.

This experience became the model for other rapid appraisals carried out in the UK. Based on this experience a group of doctors in general practice in a poor area of Edinburgh decided to use the approach of RPA to find ways of making their services more relevant to this community (Murray, 1994). The attraction of a community needs assessment was, in part, a response to the change with the National Health Service which now had decentralised funding to local practices and had made the practices responsible for allocating these resources. The practice group in Edinburgh, serving a vulnerable community, wished to enable their scarce resources to serve the people most in need in the most equitable way possible.

The appraisal team consisted of a general practitioner from the practice health centre, the health visitor, the local community education worker and two local
social workers. Like the team in South Sefton, it could not work full time on this exercise so it was done over three months with each team member contributing about 4 hours a week.

The team devised an interview schedule and pilot tested the protocol using the WHO rapid appraisal guidelines (the original guidelines published in 1988). Interviews were conducted with key informants who included local health service people, teachers, workers in voluntary social service organisations and seventeen residents selected to represent various age groups, social situations and health problems in the community.

A meeting was held to present the findings to all informants after which two focus groups were conducted to identify priorities and explore possible interventions. Suggestions were made about improvement of the general practice health service delivery. A final report was circulated by the team and a local newspaper published the detailed findings and invited comments.

The exercise produced several positive results. For example, one result of the findings was that community concerns with no direct links to the health service delivery, that is improvement in bus services, met with a positive response from the responsible authority. Bus services were improved. In the context of health service improvement the immediate and easily corrected actions were undertaken. In terms of a planning exercise, the team was pleased with the flexibility of the approach and that it allowed solutions to be found alongside the identification of problems.

Ong (1996) discusses the value of rapid appraisals in this context as an important way of bringing health policymakers into contact with community people. It provides opportunities to allow those often confined to offices to get a ‘feeling’ for real community problems. This objective was one which motivated the early work in RRA. However, for the practitioners and promoters of PRA/PLA this approach is limited. The ‘community’ is by definition of the authorities, the geographic community. Participation is most often a means to improve health services. Most critically, although mechanisms are in place for community participation in data collection and analysis, the decisions and resources still lie within the domain of the health managers not the community members. Few in authority, have a good comprehension of the capacity building which can be generated through support of the more participatory aspects (Cresswell, 1996). Rapid appraisals, or rapid participatory appraisals, are seen to be more extractive than empowering. Although recognised as a step in the participatory process, they do not qualify as a participatory approach as defined by Chambers (1997) and Cornwall and Jewkes (1995). They continue to tend to meet the managerial not the community needs.
Examples of professionalising action research

Hart and Bond (1995) describe professionalising action research which is designed to enhance both the professional and the individual's ability to have some control over the work situation. It focuses on giving professional groups empowerment to support concerns of patient/clients and communities. Although the professionals remain firmly in control they see ways of reflecting beneficiaries' opinions and to support these concerns in situations where more traditional approaches are undertaken and professional interests are likely to be protected against change. A relatively prolific example of this approach might be seen in the creation of community health councils which have the purpose of institutionally representing community views to professional and government bodies concerning community-identified health problems.

In an article reporting the evaluation of pilot programmes of the South Australian Health and Social Welfare Councils established in 1989, Baum and her colleagues (1997) examine this stage of participatory approaches to health care. The article is valuable because it provides a critical analysis of participation using the councils as a case study. The evaluation was carried out approximately two years after the councils were established.

Four councils were established with the objectives of increasing community participation in decision-making; increasing accountability of the welfare system; promoting community awareness and strengthening local action to promote health and prevent social and health problems (Baum, Sanderson and Jolley, 1997). The councils had an office within its geographic area and a full-time executive and half-time assistant. They also had a small budget to cover costs but relied mainly on voluntary workers and subject group organisations to carry out the work. Any member of the locality who supported the councils' aims could become a member but the councils were directed particularly to include those who were disadvantaged by the existing welfare system. The council could choose to tackle any issue it deemed relevant.

The analysis identifies three key themes emerging from this experience which determine the success of participation in these organisations. The first is structural preconditions. Here issues like secure staff and funding were seen as key. In addition, the evaluation saw the problems of integrating the more disadvantaged groups because they often did not have the time or capacity to be involved in such activities particularly with the decision-making aspects. In addition, the type and kind of leadership were seen to be critical.

A second theme was that of representativeness. The question of what and who was the community was critical in assessing this theme. Involving large numbers of community members was a problem within the two years in which these councils operated. Baum, Sanderson and Jolley (1997) raised the question of who was
involved in these councils. They note that representative democracy is not always participatory as the former often inhibits the development of the latter. Another issue concerned the problems which the councils took on. The article notes that it was rarely problems of structural change or policy but rather more mundane decisions. Taking on broader issues only makes sense when it has been agreed on all levels that collectivist strategies for public health are priority. Yet, of those interviewed, the vast majority felt the councils had made marginal impact on decisions about health services.

The third key theme was that of power. According to Baum and colleagues the two sources of power for the councils – the bureaucracies which funded the councils and the local people involved in council activities – were often in conflict. This tension is a characteristic of council existence. While it is difficult for councils to confront issues that are too controversial and might threaten their funding, the continual attention paid to such issues created an informal influence that gave power to councils which proved more important than the formal structures.

In conclusion, this study examined in the framework of participatory approaches a common organisational approach, that of the creation of community health councils. By identifying key themes from a particular case study, light was thrown on these structures as an approach to the more formal incorporation of participation within local government. It is a stage closer to empowerment than those approaches described above derived from the rapid appraisal experience because the structures were basically managed by community members. However, their scope of operation was defined by existing bureaucracies and policies for health promotion. Professionals still defined the boundaries but opened possibilities to change the parameters in the future. Definitions of community were geographic although recognised not to be homogeneous. Participation was still seen as a means to improve health services although it was also recognised that this goal might be achieved only through empowering local people. Power was held by the authorities but negotiation was a priority.

An innovative use of visualisations in the professionalising stage has been undertaken by Pridmore (1996) in the context of a child to child programme. She conducted a study in Botswana as part of a larger research programme exploring the effectiveness of using schoolchildren as health educators. The sample included 11 Bushmen children and 100 Botswana children aged 9–10 years. The Bushmen were from an isolated settlement; 85 of the others came from a rural settlement 60 km from the capital and the remaining children came from an urban slum school in the capital. The children were asked to draw pictures exploring the themes of: what makes you healthy, what makes you unhealthy and what do most people die from.

The author argues that the study was undertaken in the context of participatory research with the aim of empowering children to express their views and to have
these views taken seriously in societies that often treat children as objects. The experience was to have research undertaken with children rather than on children as means by which this group could be involved in the empowerment process.

The article explores in some detail the constraints of reaching the objective both in terms of research results and ethical implications for the use of the method because of the ease with which children can be manipulated to express adult wishes rather than their own views. To the author the most important result of the research was that children could express ideas without words and then could use words to write about the ideas. However, it could be argued that what was equally important was the benefit in the quality of information obtained and in the awareness building of teachers about both the method and the insights about children's health. In other words, the value of this method was its contribution to enabling professionals to find ways of supporting and advocating concerns children have about health, rather than focusing on children’s empowerment.

Although it is a small example of action research, it does examine some critical questions about the context of participation. It highlights the issue about how those who are seen to have authority can bring into negotiation and partnership those who by definition (in this case, children) are in a less powerful position. Advocating power is not the same as empowering people. Tools such as visualisation can bring awareness and respect but they do not necessarily catalyse the process. Advocates of PRA/PLA say this can only be done by ‘handing over the stick’, that is giving power to those who lack it. We shall now examine this stage of action research.

Examples of empowering action research

At the other end of the continuum from experimental action research is empowering action research. Reflecting the values and characteristics we have attributed to the constructs of participation and empowerment, this type is the embodiment of the principles for enabling the poor and powerless to build experience and capacity for structural changes both in their own lives and in the institutions which affect their lives. It is at this stage that case studies that use visualisations to build power sharing and those which are identified as participatory action research (PAR) can be found.

The published literature in the health field in this area tends to be of two distinct types. One type is case studies which describe the development of visualisations for empowerment and capacity building. These studies emphasise the ‘how to’ and promotional aspects of the experience. As such, they rarely examine processes in detail but rather tend to draw experiential lessons. Case studies using PAR, perhaps by their very nature being defined as research, are much more analytical and critical. Some of the best published articles to date in the health field are collected in a book edited by de Koning and Martin (1996) resulting from a conference on
this topic held in Liverpool in 1993. Selecting case studies to illustrate examples at this stage proved difficult because there are no typical examples, as for the other stages, which clearly illustrate the category under which the process should be placed. The processes here are more fluid, more dynamic and less easy to ‘box’. For this reason and for the reason that these examples do address the needs and potentials of the poor and underprivileged we are including several case studies in this section.

Descriptive case studies

Case studies which focus on the use of visualisations for community capacity building and empowerment are often in the form of explaining how to use the various visualisations and what information was gathered with this tool. They also extol the value of this approach. The case study of MYRADA provides an example which describes how an NGO pursued the objective to promote this type of participatory approach to development in India (Mascarenhas, 1992). MYRADA is an NGO which has been working in South India (Nepal and India) since the late 1960s. It has expanded its activities since that time from refugee resettlement projects to broader rural development projects. MYRADA has also been involved in the use and development of participatory methods to understand and assess rural situations and to plan for their development. Because of their commitment to participation and a role as a catalyst and partner in development rather than patron and benefactor, and because of a growing dissatisfaction with RRA methods, they developed an approach called PALM – participatory action learning methods. This has various applications, which include planning the development and management of natural resources, and planning integrated rural development programmes.

As a method and process PALM is village-based and efforts are made to break down insider-outsider barriers. It is based on five basic guidelines:

1. The time should be chosen to suit the villagers,
2. The appropriate cultural protocols must be respected and followed,
3. Expectations should not be raised, particularly if they cannot be met,
4. The programme should begin with equalising exercises in which conventional roles are reversed, i.e. the villagers take the role of the educated experts who teach the unqualified outsiders how to perform their everyday tasks such as weaving and transplanting rice, in order to enhance their status, self-esteem and interest in participation
5. Modes of interaction should be used that encourage participation, such as listening and learning, and those, such as lecturing, that discourage participation should be avoided. A range of particular methods or tools may be used in a format that is deliberately left open to allow flexibility. These tools include timelines, mappings (social and primary resource mapping and modelling) transects, seasonality, ranking and diagrams

The description of this programme relates its historical development. It highlights the changes in its orientation. It describes the principles and values it discovered in its development. However, it scarcely reflects the processes and insights which brought about changes. It may be argued that it is more prescriptive than analytical. Like other examples which we briefly describe below, it tends, as a case
study, to focus on promoting the approach and values of empowerment participation rather than examining the context, potential and, in the words of the PRA/PLA advocates, 'challenges'.

RRA (now PLA) Notes provide a great resource of descriptive case studies. The early years of this publication is replete with individual experiences mainly using visualisation tools. In its later years, it now seems to enter into a more critical dialogue about methods and approaches. However, it does continue to be a forum for support for recording experiences with visualisations for participation and project planning. The types of case studies are illustrated here by a brief description of some of those related to health and nutrition. They give a flavour of the types of articles focusing on describing experiences in systematic approaches to empowerment.

For example, Joseph (1992) describes a PRA training exercise conducted in South India with workers from a number of organisations, local and international. The purpose of the exercise was to train a group of workers in an NGO programme in Jamkhed, India to use PRA tools and methods and to get information about the existing health system. The article reviews which tools were chosen and how they were used. In conclusion, it reflects on specific lessons and states that the approach is useful as a means to clarify health issues.

Appleton (1992) reports on a PRA exercise in training and assessment carried out in an FAO (Food and Agricultural Organization) artisanal fisheries project in coastal Guinea with a focus on food and nutrition issues, conducted with local project staff who knew little about the situation. The article describes the tools used, records the results of the visualisations and highlights unexpected insights which the professional team gained. Again the conclusion focuses on what lessons the team learned from this specific exercise and a hoped-for follow-up with the Ministry of Health.

Cottam (1994) describes research in a poor urban context, La Cienaga barrio, in the Dominican Republic, part of a larger project investigating the relationship between urban women's changing roles and their health status. She wanted to examine the appropriateness of conventional biomedical definitions of health in this context. She collected data from 43 women, conducted semi-structured and group interviews, carried out three groups of exercises with women to explore definitions of health and happiness, productive roles, and health rankings. A number of tools were used: card sorting, ranking, developing matrices, scoring, comparative ranking, linkage diagrams and community mapping. Again the data results as well as the visualisation are presented. She examines which tools worked well and which did not and concludes that all methods worked well with the exception of the mapping. The discussions gave evidence of the potential of these methods to understand urban complexity; the methods were useful for work with heterogeneous groups; the flexibility of the methods enabled researchers to overcome some
preconceived ideas and the use of qualitative methods proved useful for getting information about the poor who might otherwise be inhibited by a formal questionnaire.

Welbourn (1995) edited a section of PLA Notes devoted to HIV/AIDS and this contains a number of case reports on the use of participatory approaches in HIV/AIDS programmes which included descriptions of: a PRA to assess community HIV risk factors in rural Uganda; use of PRA for promotions of AIDS awareness in Thailand; a participatory education theatre (PET) to increase HIV/AIDS awareness in Kenya; and a modified PRA approach (PRRA: participatory rural research on AIDS) developed and used in community mobilisation against HIV in Kenya. On the basis of these studies, Welbourn concludes that the use of participatory approaches and visualizations can enable people to explore community problems and to locate issues relating to sexual health, and particularly AIDS, within these. She says ‘the communities can then already begin to see the potential impact of HIV for themselves, as they look again at their own diagrams’ (Welbourn, 1995, p. 61).

The PRA/PLA approach has also been used somewhat extensively in water and sanitation projects. For example, Adriance (1995) used these methods and tools to stimulate community participation in the identification and planning of water and sanitation micro-projects, part of a larger sanitation project carried out by CARE International in Kenya. Van Wijk (1997) used the approach to review a water and sanitation project in Southern Niger which stimulated learning by both locals and outside experts and proved effective to monitor an existing programme. Almedom, Blumenthal and Manderson (1997) used some of these approaches and visualisation in a manual published to evaluate water and sanitation projects.

These types of articles are useful for those unfamiliar with the visualisation tool and/or those wishing to learn about or share experiences with this approach to needs assessment. Scrutinised carefully, they provide useful information for implementing participatory appraisals of this nature. They also identify people who have been involved in these activities and have contributed to an important network of support for PRA/PLA practitioners.

Analytical case studies
Examples of the analytical case studies make a different contribution to the literature. They focus on the wider issues concerning the development of purpose and the process of shifting power and control from experts to locals. The three examples described below give a flavour of this approach. The first is a study undertaken with blue-collar steelworkers in Australia to help them define and take some control over their health needs. The second is the development of a women’s health project in Gujarat, India which was set up at the request of the local women and resulted in the creation of a women’s holistic health centre. The third is the
study of the structural transformation of an NGO as a result of its commitment to undertake participatory action research.

Ritchie (1996) describes a study in Australia where she undertook a participatory action research project among semi-skilled blue-collar steelworkers as part of her PhD research. The purposes of this project were twofold: firstly to enable these workers to take control of and improve their health, and secondly to explore and document this process as it occurred. From the outset Ritchie was concerned that she wanted to work with participants (not do research on them), that the health problems to be addressed should be ones identified by them and not those identified by those in positions of power and control, and that she should be part of the process of change.

Ritchie describes the research process as falling into six stages:

1. **Entry**: finding an appropriate setting for the research, becoming familiar with it and inviting employees to participate.

2. **Getting to know each other**: this was partly a continuation of the familiarisation process and also gaining the acceptance and trust of participants. It took two months. Ritchie comments that being an outsider and of different gender and occupation actually encouraged the steelworkers to confide in her during this familiarisation process.

3. **Generating concerns**: the articulation of what the steelworkers perceived as their problems. At their request this was done by individual interviews rather than group discussions, largely because of the demands of the working situation and the need to attend to the furnace at any time. From transcripts of interviews, Ritchie identified priority concerns, which she fed back to the four shift teams collectively for discussion. A summary was also sent to various management figures and the union representative. Ritchie notes that this liaison formed an important part of the whole enabling process. This process took one month.

4. **Participatory action**: each shift selected a problem from the concerns identified above that they would particularly like to address. Ritchie notes that there was much interest and enthusiasm among the participants at this phase, with the main constraint to action being the difficulties of holding small-group discussions because of the problems encountered in the previous phase. This made the extent of involvement in planning and implementing meetings variable.

5. **Acting on concerns expressed**: Ritchie met with the workers over eight months to discuss the concerns identified earlier and how these could be resolved. This process was greatly aided by the company's recent adoption of total quality management, which included commitment to worker participation. This situation meant that mechanisms for worker input and training programmes for small-group actions to
improve productivity were already in place and could be used to channel the ideas emerging from this project. Despite this, Ritchie comments that her presence was a vital catalyst for discussions to occur and when absent the process halted. From discussions it emerged that although the workers could articulate their health concerns to her, they also wanted professional advice in identifying what else might be health problems. It was therefore arranged to have health risk appraisals conducted by an occupational health nurse. The workers were given the results of these, but this information was not acted upon by them in terms of making behavioural changes. Rather, the assessments seemed to be of mainly symbolic value as an indication that they were being valued and treated on a par with senior management. During this phase certain improvements in the working environment were also negotiated.

6. Reflection and evaluation: this phase covered Ritchie’s withdrawal from the project. She wrote a draft report containing her perceptions of what had happened during the project. This report was then fed back and discussed with the workers at individual interviews to confirm the contents with them. Copies were also sent to the union and the occupational health and safety department. By this time the latter had become allies in the project and were keen for it to succeed. Recommendations were thus made for the sustainability of the project mechanism. Once verified with all concerned, the final report was sent to senior management and all participants.

Ritchie identifies the following lesson from the experience: the problem of this particular working environment made group discussions impossible. Despite the difficulty of entering such an environment, being an outsider did carry some benefits, and the recent adoption of management policy created a supportive environment for the enabling process in that some mechanisms were already in place.

In contrast to male urban steelworkers, Khanna (1996) describes her experience of PAR in a women’s health programme implemented by the NGO Social Action for Rural and Tribal Inhabitants of India (SARTHI ) in a district of Gujarat, traditionally an area in which women’s status is very low. Although the health programme was not consciously planned with PAR as an integral component, it actually emerged as such. The programme was instigated at the request of the women and they were involved at all stages of the planning and implementation and, with their participation, a programme of woman-centred holistic health care was created.

The programme had three chronological phases: a maternal and child health component, action research on traditional medicines and gynaecological training through self-help. Introductory work involved workshops in which the women shared their stories and talked about their bodies, thus enabling them to explore not only their experiences of their bodies, but of their social position and how their bodies had been used to subordinate them. This in turn enabled them to develop
more positive self-images, to recognise that they could exert control over their bodies and to recognise their potential individual and collective strengths. In the traditional medicine phase, PAR was conducted via workshops and field exercises. This process empowered local women by demonstrating to them the extent of their own knowledge. Further reinforcement of this was provided by another NGO, which analysed the phytochemical content of traditional remedies and showed them to be effective. The final gynaecological training phase was a classic example of PAR. A series of training workshops were held in which the basics of gynaecology were taught through self-examination. The participants also practised upon themselves using the validated traditional remedies and other non-drug therapies. The workshop participants were local women, two of the programme planners and a facilitator. All were equal partners in this research process and it is recorded that all were transformed by it. An awareness of gender imbalances in social rights and relationships developed and from this an increased politicisation. The latter led to an increased commitment to change. The programme is now being extended in response to demands from other women. The training of further health workers is being conducted by some of the women who attended the original gynaecological training workshops.

Difficulties encountered in the process identified by Khanna were: getting women to participate who traditionally see themselves as occupying very passive roles; developing appropriate methods; gaining the participation of the women in the documentation and dissemination of their own experiences.

Lessons which Khanna identifies from the experience include: PAR requires a commitment and readiness to change and learn on the part of all participants; PAR entails personal transformation and politicisation; for organisations involved in PAR it also requires flexibility and readiness to change and a real commitment to empowerment; in relation to women's issues PAR must challenge patriarchal structures and has a higher chance of success where already challenged by feminism.

Her final comments note that participation is about more than efficient service delivery and involvement in the implementation of programmes. It is about helping communities to recognise and meet their own needs.

A case study which considers the effects of this type of participatory approach on organisational change is that of the Christian Commission for Development in Bangladesh (CCDB), an NGO which has been involved in development work in Bangladesh since the 1970s (Bloem, Biswas and Adihikari, 1996). It has always been committed to the concepts of sustainable and participatory rural development and in the 1990s has developed and implemented the people's participatory planning process (PPP). This process falls within the remit of PAR and contains a clear commitment to the development of critical awareness, particularly among the poor and socially marginalised, in order to enable people to transform their lives.
through their own actions. In this change, external agencies may play a catalytic and supportive role, but should not dominate the process.

PPP is broadly designed around the recollection and analysis of the past and present and then visualisation of the future out of which a plan of action can be identified by the people. The process comprised twelve modules or stages: 1. informing people; 2. inauguration (discussion at a festival organised by CCDB staff); 3. recollection of the past; 4. analysis of the village today using mapping to examine resources and institutions; 5. analysis of village social structure; 6. analysis of micro-macro relationships, such as relationships with other villages/districts, and the impact of external problems on the village; 7. analysis of the causes of problems; 8. responding to/addressing these problems; 9. identifying the villagers' resources available to use for their own development; 10. visualisation of the aspired-to social state; 11. development of a people's plan with the identification of programmes and activities followed by feasibility studies and verification that activities fit with people's needs and goals; 12. monitoring and evaluation.

Throughout these phases a number of methods could be used, which included visualisations and mapping and also songs and poems. Methods were used which allowed the people to remain the principal agents.

In commenting on the implementation of this process, the authors noted that the process of change which was central to PPP involved not just the participants themselves, but also the organisation. At the outset CCDB prepared for this and ran a series of training courses, workshops and seminars for staff. From these a consensus and commitment to the approach emerged, but they noted some apprehension and anxiety on the part of some staff members due to fears of job loss and cynicism regarding the ability of the people to be engaged in this process. These concerns were mostly mitigated over time and the implementation of PPP led to changes in the management and organisational style of CCDB. In relation to participants they too had mixed feelings; many were enthusiastic, but some were critical and feared the removal of material assistance from CCDB. Gaining active participation was also difficult and took time.

From the evaluation of the process a number of lessons emerged. These lessons identified constraints which included: the ability of people to analyse the macro situation of which they were a part appeared limited; the process was also very demanding of those acting as facilitators. Other constraints were the generally poor socioeconomic context and extreme impoverishment of people, the existing social structures which were very hierarchical; and the sustainability of the project if CCDB withdrew (their financial support was an important factor in holding groups together). Case studies at the stages of empowering action research have confronted the issues of community definition, participation as an end rather than a means and of power and control directly. They have chosen strategies to shift professional/outsider
attitudes in order to create environments in which local lay people not only felt respected but gained self-confidence to act upon issues which affected them personally. To reach these objectives, it was equally important to examine methods and tools which helped this process and the processes by which these tools were applied to achieve the objectives.

All these case studies show that the process is difficult. It is so because of its unfamiliarity and because it is difficult to understand and apply by professionals, because of expectations to groups working in partnerships with these professionals and because of the wider socio-political environment which often militates against pursuing these approaches to health improvements. However, the rewards of pursuing this approach in terms of both good information and sustainable changes are also evidenced in the case studies. It is, perhaps, because of this evidence that increasing interest is being shown in empowering action research.

A note on UK case studies

The use of participatory methods is a rapidly growing area in the UK and following from this situation there is a burgeoning grey literature. Many applications of participatory methods have sprung from the use of RA methodology and examples of this include the work of Ong and Murray described above. In addition many groups and organisations are exploring the more participatory PLA approaches. The applications of these approaches are very diverse and include domestic violence, HIV/AIDS, drug use, poverty, young people's needs and health promotion.

It is beyond the scope of this review to identify this literature as it has not been systematically collected or catalogued anywhere. Our experiences suggest that it is best accessed via the various networks that have developed out of this work and also via key individuals involved in this field. For this reason, we list key people in Appendix E who have access to these networks, experiences and literature.

Conclusion

The purpose of this case study presentation was to put meat on the bones of the theoretical constructs and to illustrate the use and value of some of the methods and tools we described in Chapter 4. It is critical to note that the case studies were described at a specific stage of their development. Thus, there is a tendency on the part of the reader to see the case study as static rather than dynamic. Experiences of reviewing such studies at a later time give evidence to support the view that the process was dynamic indeed and that each of the studies above has the potential, if not already realised, to move along the Hart and Bond continuum — in either direction. By presenting these studies in this form, we can explore each stage in
some detail. They provide experiences by which we can assess the value and direction of projects seeking participatory approaches.

References


6. ASSESSMENT OF CONTRIBUTIONS AND CHALLENGES OF PARTICIPATORY APPROACHES

Summary

In this final chapter we assess, based on the literature, the contributions and challenges of the participatory approaches we have examined in this review. In the first section we summarise the contributions made by these approaches to the field of health and health development. We add virtually no new literature as they are essentially a summary of the previous chapters. In the next section in the language of the proponents of these approaches, we analyse 'challenges' (not 'weaknesses') of these approaches based on both theoretical developments and experiences. The first part of this section reviews some of the concerns in the context of research and action for participatory approaches. It calls mainly upon the literature from critiques of participatory appraisals because little else in the published literature is available. The second part of this section articulates the challenges in the framework of the purpose of this review – that is to contribute to a research strategy using these approaches to address issues of social deprivation in the United Kingdom.

Contributions

Participatory approaches in health as well as in other fields of social development have directly addressed the issue of seeking ways of including the marginalised, particularly the poor, in improving their living conditions. What results have been recorded in their efforts to actively involve local people in change and to contribute to sustained improvements in their lives?

Perhaps the major contribution of participatory approaches in all fields is that they draw attention to the need to involve those who are affected by 'outsider' (government, management, local authorities) efforts in those decisions. Evidence shows that if beneficiaries/stakeholders are not involved, projects are difficult to
implement and to sustain. The case studies which we have presented, because there are few convincing generalisable experiences, suggest that people who have been involved in the planning and implementing of projects with the objective of improving their lives are more likely to support and sustain such projects. Evidence also suggests that such involvement benefits people on a personal level through the skills and education they receive by participating in such community activities.

We must note, however, that there is little concrete evidence that these approaches have been particularly supported by the poor and marginalised people. While there are many reports of projects working in areas where these people live, it is unclear whether those most in need were the most participative or who participated - the better-off, the men, etc. We discussed in Chapter 3 (see section 2 ‘What factors influence participation?’) the low priority given by many community people to health. Coupled with the fact that the poorest have little time and often see little profit in being involved in social development projects (Rifkin, 1990) we would need further evidence to assess whether the needs of the poor have been addressed and whether they have had opportunities to improve their wellbeing.

In the area of theory, participatory approaches have made methodological contributions both to the areas of information gathering and of participatory developments. In the case of the former, visualisations, as we have noted, have contributed to both quality of information and involvement of people. In the case of the latter, they contribute to a new paradigm which links soft system analysis with scientific discourse and recognises the critical role of lay people rather than only professionals/experts in the development process. They contribute to the development of the adaptive change paradigm we discussed above.

The literature suggests that the approaches have made a contribution to the amount and quality of information about a given people in a given locality. Superior to surveys in obtaining information about attitudes and opinions, the qualitative methods which are the basis of these approaches, allow professionals and community to obtain information which a more structured approach constrains. In addition, as several authors have pointed out, the participatory approaches have given rise to a still developing variety of innovative methods for improving information and the involvement of local people.

Participatory approaches are designed to build partnerships between resource holders and beneficiaries. They have contributed in this area. That professionals/planners/resource holders actually do the information collection themselves and ask opinions of those who are not on their social/professional level has several advantages. Firstly, it has the potential to strengthen the rapport between project people and community people. Secondly, the fact that the professionals/managers spend time with local people and try to find out their views gives credibility to the participatory aspects of the project. Thirdly, these approaches provide opportunities for mutual education whereby both professionals
PARTICIPATORY APPROACHES IN HEALTH PROMOTION AND HEALTH PLANNING

and lay people teach each other and gain respect for each other through that process. Specifically, they provide opportunities for education of local people both through the availability of information and skill development.

Participatory approaches in both participatory appraisals and in participatory action research have contributed to the area of improved project management. The rapid appraisal experience has explored the ideas and practice of bringing multi-disciplinary teams together to carry out work with a view to enriching both the experience of working together and the data which are gathered. Particularly in the field of health where health professionals have tended to dominate the work, multi-disciplinary teams have brought new insights about causes of poor health and have often helped strengthen the participatory element through their community work skills. Multi-disciplinary teams have added new dimensions to the value of participatory approaches in terms of strengthening actions and activities which were the results of these approaches.

Equally important is that the approaches provide opportunities for local people to gain skills and experience in project management. Being involved in setting up the data collection activities, collecting, and analysing the data are often new experiences. In addition, they have opportunities to become involved in projects which result from initial participatory exercises. Examples of these outcomes are described in the case studies on PAR in Chapter 5.

In the wider dimension of policy formulation, on an international, national, district and local level, experience records changes brought about by these approaches. The World Bank (1996) has used these approaches and has been impressed with the results in several projects in low-income countries. The Healthy Cities projects in Europe and North America have explored these approaches to improve health in urban areas. Local health boards in Canada and Australia have experimented with these approaches, with experiences in the development of local health councils, for gaining wider community involvement in health matters. The rapid appraisal experiences in the UK have been brought into the policy dialogue and have been used by several local health authorities as well as GP practices (Ong and Humphris, 1994; Murray et al., 1994). The PAR experiences have changed local situations in terms of the management of workers, project management and ways of undertaking local activities.

Challenges

The supporters of participatory appraisals and PLA in general do not use the term 'problems' or 'constraints'. Instead, in the context of positive thinking and optimism, they choose the term 'challenges' (Chambers, 1994, p. 1442). In the light of the contributions which the approaches have made and the growing support which they have generated, particularly in the context of addressing issues of
poverty alleviation and social exclusion, we think the term is warranted and so have also used it to examine some of the barriers which arise. The first part reviews concerns about participatory approaches in the context of research and action. It relies on the critiques of participatory appraisal because little other published literature is available. A recent article (Zakus and Lysack, 1998) provides critiques of community participation in general, focusing on the difficulties of translating the vague concepts into health-care practices. Other literature which we discussed above has covered this ground, often in more detail (Woelk, 1992; Guijt and Cornwall, 1995; Jewkes and Murcott, 1996). The article brings no new insights to the subject. But it does contain a useful summary of the conditions predisposing to community participation (see Table 9). We then look at the implications for addressing social deprivation using these approaches in the UK.

Mosse (1994) outlines major concerns about both PRA and participatory approaches in general. The first is that the value of any information gathered and of continuing project development depends on building rapport between the funding agency and the beneficiaries. He notes that the information gathered and the continuation of the process rests on this rapport which in turn rests on the outsider's understanding of the context and the ability to understand communications - both verbal and non-verbal. Too often outsiders hold mistaken assumptions which bias the entire process. In addition, local people have their expectations of the exercise which may not be recognised. Information provided by them might be information for their own agendas. Mosse concludes that any participatory appraisal exercise should only be undertaken when there is a reasonably good knowledge of the locality and appropriate contacts have been developed. His points extend to any participatory activity because information and communication are keys to further developments.

The second concern is focused on how 'participatory' the activity is. We have earlier noted that communities are composed of elites and socially marginalised people so it is reasonable to assume some people have better access to both the opportunities and results of these activities than others. Mosse gives some details about how these differences manifest themselves. They include the environment which allows dominant views control because of existing power structures. He notes that with rapid appraisal exercises dominant views are likely to cause bias because of the short time frame, the possibility the information will bring material benefits and the public nature of the inquiry.

The third concern, closely related to the one above, is that of gender bias where women's roles, often difficult to identify clearly, limit their opportunities to contribute to the process. They face practical constraints to participation because of time, location and unfamiliarity with this type of collective activity. They have social constraints. Finally, participatory exercises may generate social exclusion as many aspects of their lives simply cannot be included. For example, women cannot talk about violence in the marital situation which may be the primary cause
preventing their participation. It would be difficult to see, in many cultures, how this aspect may be openly addressed and may make them become even more isolated.

The final concern, specifically in relation to rapid and participatory appraisals, is whether the techniques are merely another means of information extraction rather than a contribution to participatory methodology. Mosse (1994) goes on to discuss the limits of the information which is collected, noting, as a good anthropologist, that some of this information is likely to be coded and outsiders simply do not have access to the codes. There are many examples but the one given by Richards (1995) well illustrates this point. He quotes a study by Bourdieu (1977) in Sierra Leone where there is in the local culture no concept between structure and action. He goes on to speculate about what happens in this culture where a seasonal calendar for cropping is produced. To the locals, the calendar is the outcome of what they will do, while for the outsiders/experts it is a plan of action.

PI.A Notes devoted a special issue (IIED, 1995) to investigating critical issues of practice of participatory and rapid appraisals. Like Mosse, the publication uses PRA as a springboard to investigate issues which relate to participatory approaches in general. These issues include, firstly, problems with conceptual clarity. These problems focus on the purpose of the participatory exercises (extractive or empowering), product or process, outcome or education. Another issue is that of poor training of facilitators/researchers/professional teams. Without necessary skills and experience, participatory programmes are likely to fail in any of the objectives — be it information-gathering and/or educational development. Manderson and Aaby (1992) investigate this issue in depth particularly in relation to rapid assessment procedures. A third issue, and one to which we have earlier called attention, is that of continuity and support after an initial activity whether it is needs assessment or local contributions to implementing and/or monitoring the project. The literature illustrates in detail initial steps. Very little has been written about the whole process over time. Discussions with practitioners, planners, managers and field workers suggest that all too often few mechanisms are put in place to ensure continuity and support. Early partnerships and opportunities evaporate after the initial product, usually defined as some type of participatory exercise, is completed. These issues are reflective of the use of any participatory approach in project development.

Chambers (1994) highlights dangers specific to participatory appraisals. These include: problems associated with instant fashion in which funding agencies use the umbrella to manipulate their own agendas; problems associated with the word 'rapid' in that it gives no meaning to the continuing context and support needed once the initial appraisal has been made; problems associated with the demand to formalise the approach when it is the flexibility which is a great strength; problems with routinization in which the same exercises continually repeated by the same persons lose their value in both the information-gathering and the education process because people cease to be vigilant.
Ways forward for programme development

From the above discussion, supported by the entire literature review, it is possible to identify challenges for those whose objective is to develop a research strategy using participatory approaches to address problems of social exclusion.

Project preparation

The first challenge is to give time and effort to prepare the research project. A first step is to assess whether the environment is conducive to using such approaches. In their article on community participation Zakus and Lysack (1998, p. 5) display a list of preconditions for community participation in health. This list serves as a good basis for making an assessment (see Table 9). It is equally important that those who are initiating this process clarify their goals and objectives. As we have noted, too often lack of clarity on definitions, terms, and conditions has proved an impediment to project success. As we have defined participation as a process, consensus on these issues will evolve over time. Efforts to make the process transparent is critical to its development. A third factor, when empowerment is chosen as an explicit objective, is continually to examine the researcher/expert’s attitudes and behaviours in the community. As Mosse notes, rapport building is the basis on which all activities stand or fall. In empowerment projects, experts must show respect, and facilitate the project, rejecting professional status and airs. A final step for preparation is to ensure mechanisms will be in place to provide continuity and support for the outcomes of the initial activity. As the literature argues, a single exercise is not participation. Participation can only grow when the environment enables exercises to be built upon.

Project design

The second challenge for research strategies is that of research development itself. The literature highlights several points. First is the design which needs to be flexible, innovative and responsive to change. In participatory approaches within the people’s participation and empowerment constructs, research objectives are twofold. One is to obtain information about people’s perceptions about their conditions; the other is to involve local people in an education process to create opportunities for their self-improvement. Research designs will need to reflect and give equal value to each objective.

The design will need to use appropriate methods for the questions which are being addressed. Combinations of qualitative and quantitative methods are useful but they must be appropriate. This leads to the issue of training. Good research and action depend on the participants having good skills. This view is true both for professionals and for lay people from the community who are taking part in the project. We have emphasised the use of qualitative methods for these types of
Table 9. Predisposing conditions for community participation in health

- A political climate which accepts and supports active community participation and interaction at all levels of programme development, implementation and evaluation
- A political context in which policy, legislation, and resource allocation take account of regional/local circumstances, aspirations and needs
- A sociocultural and political context which supports individual and collective public awareness, knowledge acquisition and discussion of issues and problems affecting individual and community wellbeing
- A political and administrative system which promotes and accepts decentralisation and regional/local authority for decision-making on health policy, resource allocation and programmes
- An acceptable universal level of availability and accessibility of health services for meeting basic health-care needs on a systematic basis
- A health-care delivery system in which institutions and professionals have experience with and are committed to a community orientation through such mechanisms as institutional boards, advisory groups, health committees, and community education programmes
- A health-care delivery system in which the institutions, service professionals and managers are flexible, genuinely committed and supportive, and have experience with attempting to respond to regional/local needs in collaborative and creative ways among themselves and with government
- Some experience in intersectoral activity of health services and professionals with related services such as water and sanitation, other public works, occupational health, agriculture, social services, housing, and the law
- A citizenry in possession of sufficient awareness of, and knowledge and skills in, social organisation and health-related issues
- A community in which health is a priority issue and which demonstrates widespread interest in healthy lifestyles, fitness, nutrition, disease eradication and prevention, and a safe and healthy environment
- A community that is willing to collectively accept responsibility and give their consent and commitment to community health initiatives
- A community with previous successful experience with community participation
- Responsible, responsive, and efficient media, information, and communication systems within and between communities and at various government levels
- For all concerned, the proposed participation must be perceived as meaningful and leading to prompt, visible results in addition to the achievement of important longer-term goals.

Source: Zakus and Lysack (1998)

projects and have noted that for the professional, familiarity with them is a **sine qua non** for developing a sound project. Skills for facilitating interviews and participatory activities are equally important and need to be given some priority. Professionals, also, will need to develop skills to train lay people both for project development and for personal enhancement. Empowerment is built on a partnership between expert and lay people in which both learn from each other. Training skills are critical to this process.
The critiques of participatory approaches focus on the issues surrounding bias and Mosse, above, has highlighted some of the problems. Bias is one which plagues all research and is more problematic when dealing with people who are not of the background of the researcher. The literature suggests that the reduction of bias relies on building good rapport with the community and on establishing credibility over time. Thus, it is important to know that the quality of information improves in relation to the confidence between the researcher and the community. In participatory approaches, Chambers (1981) points out it is only important to get information that can be used and that does not require a great deal of time to check its accuracy. Such information forms the beginning of action which will generate other information, reflecting in practice the value of the preliminary data collection. In blunt terms, if the information is poor, the project will fail. The recognition of possible sources of bias is important as is the recognition that not all can be overcome in a confined period of time.

Power and control

The third challenge is dealing with the issues of power and control. Throughout this review we have emphasised that these issues are inherent in any discussion about participation of communities. Researchers must deal with them on several levels. The first level is that of the use and value of information. Here are two dimensions. The first, which also contains the challenge of overcoming bias, is how information is collected and how it is used. Information can be collected from those who favour researchers' own assumptions, leaving aside those who do not. Information can be used to support programmes and ideas which researchers already have in mind. Information can be misconstrued to represent ideas which favour certain groups and not others. Additionally, in participatory approaches, there is the question about who owns the information. In empowerment programmes, ownership, it is argued, must be equal between the researcher and the lay people. This idea often goes against the grain of researchers who, nowadays, must publish or perish. Information collection from whom, for what use, and ownership, are questions about power. They will colour the outcomes of a project and bring into question its credibility.

Another level of concern focuses on the information itself and on the issue of control. As Mosse points out, there is the question of whether exercises such as those generated in participatory appraisals are generated by the professional/expert not by the community. The question arises of whether these exercises are empowering or constraining. Are we teaching local people to think in our terms and use our language in order to be able to use the information which we elicit? Is this empowering in that they gain skills to obtain access to our resources? Or are we undermining a local culture, construct and pride which provide coping mechanisms for their own lives?
In addition, the question arises whether our use of participatory approaches in all situations actually works for the betterment of local people. Is the presence of outsiders raising expectations which can easily be manipulated by local elites to gain resources and advantages? Is it not possible that elites get involved in these projects and continue to hold power because of their manipulative skills, leaving the socially marginalised still on the margins (Richards, 1995)?

These questions lead to an area which is not often discussed in detail in the literature – that of conflict. There are experiences which have confronted these issues over the years – some in the published literature (Shah and Shah, 1995). Recorded experience revolves around new realisations by those who are being manipulated by existing elites and then try to assert their new-found confidence. The result is that to protect their interests, the elites use force against those trying to gain resources, resulting in injury and even death to the already socially excluded. As we have suggested, participation by its nature challenges the status quo. We have little information how such conflict is managed or mismanaged and what lessons there may be for others. Shah and Shah (1995) rightly point out more research is needed in this area. The challenges over issues underpinning power and control are key to the development of participatory projects. In practice the question is how transparent this issue is in any project and what mechanisms can be developed to deal with tensions and conflict over this issue in order to gain a positive result for the project managers and the beneficiaries.

For those who wish to undertake research based on participatory approaches, these challenges must all be taken seriously. While the literature offers analytical frameworks to assess the challenges and experiences which offer some guidance on how to proceed, to date the guidelines cannot be written to ensure that these approaches will succeed in meeting goals and objectives which are so firmly rooted in ideological, theoretical and cultural assumptions about society, communities and social behaviour.

References


Appendix A. Guidelines for assessing participatory action research

These guidelines were developed by George, Green and Daniel (1996), at the request of the Royal Society of Canada Study on Participatory Research in Health Promotion, for the evaluation of grant applications purporting to be participatory.

A. Participants and the nature of their involvement

1. Is the community of interest clearly described or defined?
2. Do members of the community participating in research have concern or experience with the issue?
3. Are interested members of the community provided with opportunities to participate in the research process?

B. Origin of the research question

4. Did the impetus for the research come from the defined community?
5. Is an effort to research the issue supported by members of the defined community?

C. Purpose of the research

6. Can the research facilitate learning among community participants about individual and collective resources for self-determination?
7. Can the research facilitate collaboration between community participants and resources external to the community?
8. Is the purpose of the research to empower the community to address the determinants of health?
9. Does the scope of the research encompass some combination of political, social and economic determinants of health?
D. Process and context – methodological implications

10. Does the research process apply the knowledge of community participants in the phases of planning, implementation and evaluation?
11. For community participants, does the process allow for learning about research methods?
12. For researchers, does the process allow for learning about the community health issue?
13. Does the process allow for flexibility or change in research methods and focus as necessary?
14. Are procedures in place for appraising experiences during implementation of research?
15. Are community participants involved in analytic issues: interpretation, synthesis and the verification of conclusions?

E. Opportunities to address the issue of interest

16. Is the potential of the defined community for individual and collective learning reflected by the research process?
17. Is the potential of the defined community for action reflected by the research process?
18. Does the community reflect a commitment by researchers and community participants to social, individual or cultural actions as a consequence of the learning acquired through research?

F. Nature of research outcomes

19. Do community participants benefit from the research outcomes?
20. Is there attention to, or an explicit agreement for, acknowledging and resolving in a fair and open way any differences between researchers and community participants in the interpretation of the results?
21. Is there attention to, or an explicit agreement between, researchers and community participants with respect to ownership of the research data?
22. Is there attention to, or an explicit agreement between, researchers and community participants with respect to dissemination of the research results?

Appendix B. A brief review of core qualitative methods

Interviewing

Interviews are the most common method used in qualitative and participatory work. There are formal types of interview, with one other person or a group where an interviewer/facilitator uses guidelines to talk directly about different topics. There are also the less formal interviews which take place in relation to visualisations which we discuss in Appendix C. In these circumstances, the visualisation is the main source of information which discussions/talking help to clarify and/or probe about ideas which have been expressed.

For participatory approaches, individual interviews – unstructured and semi-structured – are the main types of interviews. Unstructured interviews are based on topics chosen by the interviewer/facilitator but without any questions or direction provided. The person being interviewed has the freedom to go in any direction and cover any topic. The basis of the good interview is the ability of the interviewer/facilitator to probe effectively. Strengths of unstructured interviews include the format of allowing the interviewer to respond to individual situations and differences in the persons being interviewed. It has value in triangulating information with observations and in seeking expressions appropriate to more tightly constructed interviews. It also has value for establishing rapport with individuals and for investigating sensitive, that is sexual topics. The weakness of this type of interview is that it is difficult to systematise as each interview tends to be unique.

Semi-structured interviews use written guidelines to give form and direction to the discussion. Although the research is free to follow leads which come up there is a clear set of instructions as to the main topics to be covered. Examples of semi-structured interviews include: 1. case studies which collect information in depth from individuals about a specific interest; 2. life histories which look in depth over the life of individuals. The strength of this type of interview is that it allows the interviewer to make the best use of the time available to get specific pre-defined information. It is often used to get information in project situations. The weakness is that for it to be most useful, time must be found to identify the relevant questions and topics.

Group interviews include focus group interviews and general group interviews. Focus group interviews are composed of a group of individuals, 4–12 in number who have been purposively selected because of a common experience and characteristics identified for investigation by the interviewer/facilitator. It therefore takes time to organise a focus group. The people usually do not know one another.
Topics and criteria for inclusion are selected beforehand thus distinguishing focus
groups from other types of group interviews. They must be facilitated by a trained
moderator and include at least one other person to record the information. The
strengths of focus groups include: 1. more information produced quickly in a lively
manner with less cost to interview; 2. provision of a range of information as
opposed to an individual opinion; 3. creation of a comfortable environment
because people have experience talking in groups. The weaknesses include: 1.
interviewer/facilitator has less control over the information; 2. it is not possible to
tell the frequency or distribution of beliefs; 3. time limits the amount of
information covered because more people contribute to one topic; 4. facilitator
requires experience and skill; 5. note-taking is difficult.

General group discussions are groups of people who usually form ‘natural’ groups,
that is they are not purposely selected and they can know one another. People
who belong to the same organisation is one example. Or people who are waiting to
see a doctor and are willing to participate in an interview is another example. These
discussions could be either unstructured or semi-structured. Also can use the
visualisation methods discussed in Appendix C. The strength of these types of
interviews is that they are easy to organise and are more natural, thus allowing
information to flow more easily. The weakness is that they are not as formal, so
intergroup comparisons are more difficult.

Observations

Observations present one method of triangulating information gained from
interviews and/or documents. As Hudelson (1994, p. 26) points out, because of our
own propensity due to time, experience and culture to observe what we choose,
observations can only limit bias in direct proportion to the extent to which they are
focused and systematic. Observations can record people’s behaviour or signs and
indicators of that behaviour. They can be unobtrusive and non-reactive or overt and
reactive. Figure 17 illustrates the degree of involvement of the researcher in various
types of observations.

Most observations in the context of action research are participant observations.
This means the researcher is involved in activities with the people in the community
of investigation. Usually the people are aware of the purpose of the researcher and
to varying degrees are aware observations are happening. This type of observation
produces descriptive accounts. The strengths of participant observation include:
1. it facilitates other data collection as the community becomes more comfortable
with the researcher; 2. it enables the researcher to discover appropriate language for
questions; 3. it provides a culture context for information; 4. it is useful to
familiarise the researcher with the environment particularly when it is new; 5. it
enables the researcher possibly to discover information hidden from public view or
find out views of insiders rather than outsiders; 6. it facilitates understanding the
values, norms, events, process and context of the situation. The weaknesses are:
1. it is time-consuming and can take weeks or months to yield good unbiased information; 2. to do it well the researcher must speak the local language, have a good memory and write long notes; 3. it could happen that the researcher becomes so familiar with the situation that he/she fails to notice unusual behaviour.

Documents

Documents are another source of information which enable the researcher/facilitator to discover information about a specific situation and confirm or question other information collected. To reduce bias, search for both published and

<table>
<thead>
<tr>
<th>Role of the observer</th>
<th>Degree to which those observed know that they are being observed</th>
<th>Degree to which those observed know why they are being observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full participant observer</td>
<td>Covert, observation as outsider</td>
<td>False explanations given to everyone</td>
</tr>
<tr>
<td>Overt everyone knows</td>
<td>Duration of observations</td>
<td>Long-term multiple observations</td>
</tr>
<tr>
<td>Full explanation of real purpose to everyone</td>
<td>Focus of the observations</td>
<td>Broad focus, holistic view sought</td>
</tr>
<tr>
<td>Single observation, limited duration</td>
<td>Type of data produced</td>
<td>Quantitative data, based on pre-determined observation list</td>
</tr>
<tr>
<td>Narrow focus, single behaviour observed</td>
<td>Open, descriptive accounts, qualitative data</td>
<td></td>
</tr>
</tbody>
</table>

Fig. 17. The range of variation in how observations may be conducted

Source Hudelson (1994)
unpublished information must be undertaken. It is the latter which is most difficult to locate but often provides the richest information. Grey literature, as unpublished materials are often called, can be found in many sources. Government reports, PhD theses, annual reports of organisations, and consultant reports are just a few of the kinds of information available. To be confident that all information collected is as valid as possible, the researcher needs to be committed to searching out the grey literature and to follow all leads which might unearth new information.

References

Appendix C. How to use the most popular visualisation tools

Drawing maps

- Before visiting the field obtain maps and/or aerial photographs of the area.
- Prepare simple outline maps showing key features and landmarks.
- Mark in roads, rivers, canals, schools, mosques, churches, government offices, etc.
- In the field obtain a spatial overview through general exploration, a view from a high vantage point (watertank, hill, tree, high building), and group interviews.
- Obtain local names.
- Revise the maps and add more detail throughout the fieldwork as you receive new information.

Maps can be drawn for many topics:

- demography
- social and residential stratification (wealth, ethnicity, religion)
- a village’s use of natural resources
- fields and land use
- spatial arrangement of a house/use of space by different social groups
- mobility
- water
- soils.

Transect

A transect is a diagram of main land use zones. It compares the main features, resources, uses, and problems of different zones.

Steps in preparing a transect:

- Find community members who are knowledgeable and willing to participate in a walk through their village and surrounding areas.
- Discuss with them the different factors to be drawn in the transect (crops, land use, trees, soils, etc.) and which routes to take.
- Walk the transect.
- Observe, ask, listen (don’t lecture).
- Discuss problems and opportunities.
- Identify the main natural and agricultural zones and sketch distinguishing features. For each zone describe:
  - soils
- crops
- livestock
- problems
- solutions
- opportunities.

- Draw the transect.
- Cross-check the transect with key informants.

**Method:**

- Use squared paper, and outline topography at the top.
- Generalise impressions, do not be too detailed.
- Include a rough measurement of the scale of the transect.
- Revise the transect throughout the fieldwork.

**Seasonal calendar**

This is a calendar showing the main activities, problems and opportunities throughout the annual cycle in diagrammatic form (it really is a series of different diagrams shown on a single sheet). It helps identify the months of greatest difficulty and vulnerability, or other significant variances which have an impact on people's lives. A seasonal calendar can be used to summarise, among other things:

- indigenous seasons
- climate (rainfall and temperatures)
- crop sequences (from planting to harvesting)
- crop pests and diseases
- collection of wild fruits and herbs
- livestock (births, weaning, sales, migration, fodder)
- livestock diseases
- income-generating activities
- labour demand for men, women and children
- prices
- marketing
- human diseases
- social events
- types and quantity of cooking/heating fuel
- migration
- income and expenditures
- debt
- quantity or type of food consumed (diet)
- annual holidays.
Daily route diagram

A daily routine diagram helps us to collect and analyse information on the daily patterns of activities of community members and to compare the daily routine patterns for different groups of people (for example women, men, old, young, employed, unemployed, educated, uneducated) and seasonal changes in these patterns. Encourage community members to draw their own daily routine diagrams.

A daily routine diagram is similar to a seasonal calendar in that it helps identify time constraints (shortages) and opportunities. For example, it can help in identifying the most appropriate time in the day for a women’s training course.

The daily routine for an individual can be completed either through an interview, through direct observation, or both. It is useful to cross-check results by using more than one method.

Ranking

Ranking or scoring means placing something in order. Analytical tools, such as ranking, complement semi-structured interviewing by generating basic information which leads to more direct questioning. They may be used either as part of an interview or separately. Pairwise ranking, for example, helps identify the main problems or preferences of individual community members, and their ranking criteria, and enables the priorities of different individuals to be easily compared.

Strengths of ranking:

- useful for sensitive information, especially for income or wealth. Informants tend to be more willing to provide relative values regarding their wealth than absolute figures (‘Rank your income sources by importance’ rather than ‘How much do you earn?’)
- ranking scores are easier to obtain than absolute measurements.

Ranking methods include:

- preference ranking (ranking by voting)
- pairwise ranking
- direct matrix ranking
- wealth ranking.

Guidelines for ranking

- Let people do it their own way
- Use people’s own units of measurement

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• Use people's own names for whatever is to be ranked
• See if you can adapt local games for ranking
• Probe the reasons for the order of the ranking
• Be prepared
• Be patient.

Direct matrix ranking
Direct matrix ranking allows the PRA team to identify lists of criteria for a certain object. It allows the team to understand the reasons for local preferences for such things as tree species or crop varieties. The criteria are likely to change from group to group and women may have different criteria for choosing certain trees than men.

Steps in direct matrix ranking
1. Choose, or ask people to choose, a class of objects which is important to them (e.g. tree species, cooking fuel types, fruit).
2. List the most important items (3–8 items).
3. Elicit criteria by asking:
   ‘What is good about each item? What else? (continue until no more replies)
   ‘What is bad about each item? What else? (continue until no more replies).
4. List all criteria.
   • turn negative criteria into positive by using opposite (e.g. ‘vulnerable to pests’ becomes ‘resists pests’)
5. Draw up a matrix.
6. For each criterion ask which object is best:
   • ‘which is best, then next best?’
   • ‘which is worst, then next worst?’
   • of the two remaining ask, ‘Which is better?’
7. Ask: ‘Which criterion or factor is most important?’
8. Force a choice: ‘If you could only have one of these, which one would you choose?’

Preference ranking
Preference ranking allows the PRA team to determine quickly the main problems or preferences of individual villagers and enables the priorities of different individuals to be easily compared. Voting is also a form of preference ranking.

Steps in preference ranking
1. Choose a set of problems or preferences to be prioritised. This could be, for example, farming problems or preferences for tree species.
2. Ask the interviewee to give you her favoured items in this set, in order of priority. Get a list of 3–6 items from each interviewee.
3. Repeat for several interviewees.
4. Tabulate the responses.
Pairwise ranking

Pairwise ranking allows us to determine the main problems or preferences of individual community members, identify their ranking criteria, and easily compare the priorities of different individuals.

Steps in pairwise ranking

1. Choose a set of problems, or preferences, to be prioritised. This could be, for example, farming problems (or preference for tree species).

2. Choose, with the help of the interviewee (or from previous discussions with a key informant), six or fewer of the most important items in this set (e.g. types of trees).

3. Note down each of the six items on a separate card.

4. Place two of these in front of the interviewee and ask the person to choose the bigger problem (more favoured preference), and to give reasons for the choice. Mark down the response in the appropriate box in the priority ranking matrix.

5. Ask whether the other of the two problems/preferences is in any respect more important/more popular than the first. Note down the criteria in the ranking criteria matrix.

6. Present a different pair and repeat the comparison.

7. Repeat steps 4 to 6 until all possible combinations have been considered (all boxes of the matrix have been filled).

8. List the problems/preferences in the order in which the interviewee has ranked them by sorting the cards in order of priority.

9. Check with the interviewee whether any important problems/preferences have been omitted from the list. If there are any, place them into the appropriate position in the ranking table.

10. As a useful cross-check to the responses, complete the ranking session by asking the interviewee about the biggest problem (or most favoured preference) in the list (e.g. ‘If you could grow only one vegetable variety, which one would you choose?’). This question is also useful if more than one item in the list scores highest.

11. Repeat the pairwise ranking exercise for a number of individuals and tabulate their responses.
Diagrams

A diagram is any simple model which presents information in an easily understandable visual form.

Value of diagrams:

- they greatly simplify complex information
- the act of constructing a diagram is an analytical procedure
- they facilitate communication
- they stimulate discussion
- they increase consensus among team members
- they are an excellent way to involve community members and to discover their views and categories by encouraging them to draw diagrams on their own.

Possible diagrams include:

<table>
<thead>
<tr>
<th>Concept</th>
<th>Diagram</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space:</td>
<td>map, transect</td>
</tr>
<tr>
<td>Time:</td>
<td>seasonal calendar, daily routine chart, time trends, historical profile</td>
</tr>
<tr>
<td>Relations:</td>
<td>flow diagram, livelihood analysis, systems diagram</td>
</tr>
<tr>
<td>Decisions:</td>
<td>decision tree, Venn diagram</td>
</tr>
</tbody>
</table>

Flow diagram

A flow diagram shows causes, effects and relationships between key variables.

Examples:

- relationships between economic, political, cultural and climatic factors causing environmental degradation
- flow of commodities and cash in a marketing system
- production cycle for a major commodity
- effects of major changes or innovations (impact diagrams)
- organisation chart.

Steps:

- Select processes or relationships to be analysed.
- Obtain information from secondary sources and from key informants.
- Keep diagrams simple, less than 20 boxes.
- Use boxes for key variables, and arrows to connect boxes.
- Include prices and/or quantities alongside arrows in production cycles.
- Use + or − in impact diagrams to indicate positive or negative relationships.
- Ask community members to draw their own flow diagrams.
**Venn diagram**

A Venn diagram (named after the man who created it) shows the key institutions and individuals in a community and their relationships and importance for decision-making.

**Steps:**

- Identify key institutions and individuals responsible for decisions in a community or organisation.
- Identify degree of contact and overlap between them in terms of decision-making. Overlap occurs if one institution asks or tells another to do something or if they have to co-operate in some way.
- Obtain information from secondary sources, group interviews, or from key informants.
- Cut out (or draw) circles to represent each institution or individual.
- Size of circle indicates importance or scope.
- Arrange as follows:
  - Separate circles = no contact
  - Touching circles = information passes between institutions
  - Small overlap = some co-operation in decision-making
  - Large overlap = considerable co-operation in decision-making.

- Draw the Venn diagram first in pencil and adjust the size or arrangement of circles until the representation is accurate. When you are satisfied, go over the pencil with a marker for easy reading. Experiment with different materials.
- Encourage community members to draw their own Venn diagrams.

*Source: J Theis and H Grady. *Participatory Rapid Appraisal for Community Development* (International Institute for Environment and Development & Save the Children Fund, 1991).*
Appendix D. Methodology of literature review

As noted in Chapter 1, this document is a critical and state-of-the-art review of the use of participatory approaches within the health and policy spheres with special reference to health promotion and the socially excluded in the UK. Given the ever-growing literature on participatory approaches, much of it disease-focused and describing applications in a developing country context, it was agreed that a selective and critical rather than comprehensive approach to the literature review should be taken. A systematic and hierarchical approach was taken to the literature identification, selection and critical review as recommended by the NHS Centre for Reviews and Dissemination at York University, and a series of inclusion and exclusion criteria was defined in order to identify the relevant literature and exclude that which was not pertinent.

Inclusion/exclusion criteria

(a) Topic/subject
Included:

- community participation/involvement
- participatory appraisals
- rapid appraisals
- participatory action research

Excluded:

- references relating to the education of health professionals
- references relating to CHWs/VHWs
- most disease-orientated applications (selected examples are included as case studies to illustrate the use of particular methods)
- reproductive health and HIV/AIDS

(b) Location/study population
Included:

- all examples of use of these approaches in the UK
- selected case studies from other countries, which provided a good illustration of the use of different participatory methods

Excluded:

- descriptions of the use of participatory methods outside the UK, with the exception of those above
(c) Study design and content
Included:

• descriptions of actual applications
• evaluations and assessments of these
• descriptions of methods and tools
• descriptions of theoretical frameworks and conceptual issues
• selected reviews

Excluded:

• advocacy documents
• rhetoric

(d) Reference type
Included:

• all published material, i.e.
  journal articles
  books
  book chapters
  conference proceedings

Excluded:

• unpublished material/grey literature (this was originally investigated but proved unfeasible to undertake within the parameters of the project).

Bibliographic source materials
A range of bibliographic source materials was searched using the criteria described above. These comprised:

• Medline
• Popline
• Science Citation Index (SCI)
• Social Science Citation Index (SSCI)
• Health Management Information Consortium Database.

In addition bibliographic references lists were examined. Also, to identify any relevant grey literature and UK-based activities relevant experts, organisations and individuals in the field were contacted (see Appendix E).
Appendix E. UK networks

As noted earlier in the review, the focus of community participation in the UK has historically been in the context of community development rather than health. Community development has a long history in the UK, dating back to the early twentieth century. This is described in *Community Involvement in Health* by Jan Smithies and Georgina Webster (Ashgate Arena, 1998). The former HEA has also funded a project to establish a database of experiences and projects in community participation. This was undertaken by Labyrinth Training and Consultancy. There are also a number of networks which have been established to share information, experiences and expertise. There are at present two principal national UK networks:

Community Health UK
This is based in Bath and publishes a journal *Community Health Action*. The membership is principally voluntary organisations. It was formed in 1992 from a relaunch of the National Community Health Resource (NCHR), which had previously co-ordinated the Community Health Movement in the UK. The NCHR had itself been formed from a merger in 1988 of two similar organisations, the London Community Health Resource (LCHR) and the Community Health Initiatives Resource Unit (CHIRU).

Community Development and Health Network UK (England)
c/o 356 Glossop Road
Sheffield S10 2HW

This was formally launched in 1997 and is still developing.

In addition to these national networks there are established regional and local networks, for instance in Scotland and Northern Ireland. The Community Development and Health Network (UK) can provide contact information for many of the regional networks. There is also a sub-group on community participation within SHEPS (Society of Health Education and Health Promotion Specialists), which is co-ordinated by Lee Adams of Sheffield Health Authority. Individuals and organisations in the health promotion field who can provide access to information on these activities and networks are:

Lee Adams
Sheffield Health Authority
Westbrook House
Sharrow Vales Road
Sheffield S11 8EU
Linda Tock
Co-ordinator
Hull and East Yorkshire Participatory Appraisal Network
Hull Education Centre
Coronation Road North
Hull HU5 5RL
Tel. 01482 616614

Labyrinth Training and Consultancy
7-9 Prince Street
Haworth
West Yorkshire BD22 8LL
Tel. 01535 647443
Appendix F. Books on participatory approaches


As part of its exploratory research programme on inequalities and vulnerable groups the Health Education Authority set up ten expert groups (with seven key population groups (older people, low income groups, the homeless, refugees, people with mental health problems, lone parents, and children and young people) and with three different approaches (community, primary health care and mass media).

As a result of these consultations the HEA commissioned a literature review of Participatory approaches in health promotion and health planning. This work was carried out by Drs Susan Rifkin, Gillian Lewando-Hundt and Alizon Draper at the London School of Hygiene and Tropical Medicine. This report contains a critical review of the contribution of participatory approaches to health promotion, including an assessment of the opportunities and challenges that they currently present. These are examined in the context of poverty alleviation and the reduction of health inequalities, issues central to health promotion in the UK today. The review also contains information on the methods and tools used in participatory approaches, illustrative case studies and information sources.