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PRA training for health workers

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• Background

I was invited to conduct a Health-PRA workshop as a part of the course on ‘Socio-economic Environment of Health’ at the Health Services Management Centre, School of Public Policy, University of Birmingham, UK. The workshop was held from the 8th to the 10th of December 1993 at the Health Services Management Centre, Birmingham University. It included a field visit to Sparkbrook, Birmingham on the 10th December. The participants were health personnel mostly from the Third World. I had asked the course organisers to arrange a field visit for the participants so as to enable them to actually try and apply the PRA methods in the field.

The workshop commenced in the afternoon of 8th December with nine participants. The participants formed into three groups of three each. The participants named the groups after three drugs: ‘septran’, ‘anacin’ and ‘paracetamol’. Each group consisted of one woman and two men. The participants had not been exposed to participatory methods before and were looking forward to the workshop. However, some of them had been involved in designing health questionnaire-surveys and were able to pin-point some major problems associated with designing and using such questionnaires.

• Introduction to methods

Approaches to health care

The introductory session was followed by the trainer presenting three anecdotes on community health. These anecdotes were from different villages of the Third World and

raised issues on various approaches to health care in rural areas and their performance. This was followed by a show of cartoons on two different approaches to health care. They compared the lecture method with the participatory approach. This led to a discussion on professional attitudes and beliefs which are not conducive to participation in health. Rural Development Tourism was also demonstrated through cartoons.

Next was a slide show on how to approach people with regard to health care. At this point, the three groups were asked to list different ways of approaching people for participation in health so as to build rapport with them. While discussing different ways of approaching local people in a community an interesting issue was raised as to whether one should accept food from a T.B. patient in order to build rapport with him or her. The group was of the opinion that a definite answer was not possible and much depended on the particular situation. The group appreciated that many health workers would be against accepting food from very sick patients even if it meant better rapport building. They suggested ways in which such food could be diplomatically avoided without hurting the feelings of the patient and at the same time learning about his problems.

Semi-structured interviews

The next session was on semi-structured interviews and how to conduct them. The session included illustrations of the kind of questions; open/probing or closed and/or leading, body language, approach and so on; meant for participatory inquiry. A slide show on different body postures and other attitudes reflected in body language were presented. This was followed by role playing by each

group for probing on a particular theme on health. In each group, one participant played the role of a villager, another a health worker and the third was an observer. After ten minutes of role play the roles were interchanged within the group. The observer kept track of the approach of the outsider, his/her body language, kinds of questions asked, nature of probing and other details and would come and present his/her observations and remarks. This would then be discussed amongst the participants.

Mapping

The next item on the agenda was the method of mapping when each participant was asked to draw his/her neighbourhood map. The method was explained followed by illustrations of health maps, health service maps, body maps, health well-being maps, mental health maps and other maps and the significance discussed. Then was a slide show on mapping which raised different questions, including whether people were able to draw maps in each country and whether maps were culturally neutral. One of the participants from Pakistan asked whether drawing maps was possible in his country. I described IIED's training at Punjab in Pakistan where farmers drew complicated farm maps and impact diagrams and explained them as well.

Matrix scoring

This was followed by a session on matrix scoring using many examples from the area of health. The slide show on matrix scoring related to different countries and raised a variety of issues. Then followed a practical run of matrix scoring by the participants. All three groups appeared very enthusiastic about the practical run and used matrices to explain topics such as 'social practices in Africa', 'joyed by the participants' and 'evaluation of the present course'. Some interesting aspects of the practical run were that the participants used seeds to score on their themes; two groups used fixed scoring while the third did free scoring. One group did the scoring by individual voting and used two kinds of seeds for positive and negative scoring by individual group members.

Seasonality and physical transacts

After the session on matrix scoring we had two short sessions on seasonality and physical transacts, again in the light of participation in health. These were followed by a discussion of a case study on Health PRA in an Indian village done by Dr. Jaythilak and Ishita Roy.

The case study raised several issues, especially about applications of appropriate methods to study different aspects of health. Different aspects of community health which were left out by the case study were suggested by the participants, together with methods and policy suggestions were made on that behalf. This was followed by a 'what if' analysis in the area of community health. This helped the group to form group contracts for the field visit.

The field visit

This was conducted in Sparkbrook on the third day of the workshop, and was followed by a feedback session the same evening. Sparkbrook is one of the urban areas in Birmingham which is considered to be socio-economically depressed and whose major ethnic groups originate mostly from South Asia. During the field visit, the participants had the opportunity of applying some of the participatory methods which they had learnt in the training session.

• Some reflections on the workshop

The workshop was quite productive and thought-provoking and had many learning points for future workshops in this area. Some of these points are as follows:

- *Infrastructural support.* The room for the workshop was spacious and good enough for the training activities of the nine participants. Seeds/papers/other workshop materials/slide and overhead projectors were also arranged and kept ready for the workshop.
- *Other support.* The active involvement of a research student, Sarah Crowther (from Birmingham University), in the workshop

was of great support to the trainer. It was this researcher who made contacts for the field visit by making arrangements with a local NGO called 'Ashram'. Her views and comments on different points raised by the participants enriched the discussions at the workshop.

- *Workshop style.* The workshop style aimed to make the participants feel involved, actively share their experiences and have enough flexibility to influence the course inputs in the workshop in terms of their requirements. After each session their views and comments were taken into account to appraise the running of the workshop. One point for trainers in this context is to have as many illustrations as possible from different countries of the world and exchange experiences with the participants as and when possible. This is important when there is an international mix of participants in a course.
- *Matured participants.* The participants had several years of experience in health care and its administration in different countries of the Third World and could easily relate their experiences in the context of participation. There was a mix of experience from Ethiopia, Pakistan, Saudi Arabia, India, Nigeria, Sudan, Thailand and UK.
- *Field visit.* Arranging a field visit through an NGO made matters simpler in terms of acceptance to the community visited and rapport building. The NGO already had good working relations with the community and were involved in training and counselling mainly of the women members of the community.
- *Methods in an urban context.* It is interesting to see how the methods worked in an urban context. The participants tried to facilitate applications of mapping, matrix scoring, seasonality and transects as well as semi-structured interviews. In each case, individual views of a few community members were expressed which could not be validated with other community members due to shortage of time.

The kind of mapping used in a village may not be possible in an urban community. In a village relationships are often informal and face to face. People live and work there and they carry their mental maps of their localities. In the urban setting of the North, people are relatively more formal and interactions are mainly through phone rather than face to face. Many of them are able to draw the area map but not able to identify all the households in the locality by names and other characteristics due to limited information.

- *Group interaction.* An image which the participants had unconsciously put in their minds (perhaps from the slide shows) was that of PRA with community participation by gathering community members at one common place. In the field trip it was realised that such community participation was not feasible in all communities for different reasons. Although people of one Asian community predominated the locality the relationships were formal as compared to those of rural life or even urban slum.

The participants were looking for bigger groups of the community to interact with or for some form of community participation in bigger spaces. However, local people could either be met individually or in small groups of six or seven members. The space in the local NGO was also not suitable for large group interactions. NGOs used their space for interaction with smaller groups for training and counselling purposes.

- *Time Constraints.* Time was a major constraint in the workshop and hence limited methods were covered. The field visit was also of a very short duration, undertaken basically for providing the participants with field exposure rather than going in for any proper appraisal. Many of the methods were distributed as handouts since they could not be covered in the workshop. Other handouts on health PRA were also circulated but it would have been better if some of them had been circulated as reading material before the workshop commenced.

- *Trainer from the South.* The participants were mainly exposed to trainers from the North in the course which they were attending. A PRA trainer from the South coming to train in the North was a major surprise for them. They were amazed as to how this could happen especially when the trainer was a person from social discipline and was not a community health specialist or a medical personnel. My background in PRA was stated while I was being introduced and when informally interacting with them I spoke about how participatory research in community health was catching on and how we were moving from place to place to learn from rural people and slum dwellers about their health conditions, problems and priorities in their own language. I felt that rapport building between trainer and participants in the workshop, became quick and easy because of my experience of the Third World. Often it appeared that my illustrations and slides were speaking the same language as theirs.

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