Editorial

• Theme issue

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

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

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

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

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

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

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

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

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

• In this issue

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

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

Regular features

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

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

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

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

Call for experiences!

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

1

Searching for participatory approaches: findings of the Yunnan PRA Network

Lu Xing

• Introduction

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

• Challenges in rural development

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

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

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

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

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

participatory approaches to rural development in China.

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

• Applications to research projects

Surveys and assessments

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

Planning

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

Participatory monitoring and evaluation

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

• Applications to action projects

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

Social forestry projects

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

Community-based conservation and development

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

Improvement of shifting cultivation practices

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

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

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

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

• Application to other projects

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

• Thoughts on participatory approaches

Theory and philosophy

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

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

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

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

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

Enabling environment

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

• Future directions

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

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

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

- **Lu Xing,** Rural Development Research Center, Yunnan Institute of Geography, No. 20, Xue Fu road, Kunming, Yunnan 650223, P.R. China. Email: ydikm@public.km.yn.cn

ACKNOWLEDGEMENTS

I would like to thank all members of the Yunnan PRA Network who carried out most of what I have written about in this paper. Thanks are also due to Mr. Andreas Wilkes, a researcher based at Rural Development Research Center, who gave his comments and helped edit the paper. For a full list of references mentioned in this paper, please contact the author.

2

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

Marc P. Lammerink, Bram Posthumus and Willem van Weperen

• Introduction

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

A brief history of the fair

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

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

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

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

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

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

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

A market of ideas

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

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

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

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

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

• Scale matters

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

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

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

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

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

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

• Is the message getting through?

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

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

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

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

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

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

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

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

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

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

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

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

• A future fair - lessons learned

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

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

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

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

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

• **Marc P. Lammerink,** FMD Consultants, Santpoorterstraat 17, 2023 DA Haarlem, The Netherlands. Email: fmd.nl@wxs.nl **Bram Posthumus**, journalist, Rijnsburgstraat 78-I, 1059 AX Amsterdam, The Netherlands. Email: jono@xs4all.nl , **and Willem van Weperen**, ETC Ecoculture, P.O. Box 64, 3830 AB Leusden, The Netherlands. Email: office@etcnl.nl

Sexual and reproductive health

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

Andrea Cornwall and Alice Welbourn

• Introduction

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

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

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

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

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

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

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

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

Breaking down walls: SRH, rights and development

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

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

SRH - A human rights issue

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

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

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

A triple taboo: gender, sex and death

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

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

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

A fourth problem: whose priorities?

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

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

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

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

HIV – a growing picture

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

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

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

• Participatory approaches – what can they offer?

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

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

Addressing vulnerability

Edstrom et al. (this issue) set out the context in which this change in approach has come about, highlighting the limitations of conventional Information Education and Communication (IEC) strategies and illustrating the opportunities participatory approaches open up for

[2] Many of these new infections were related to intravenous drug use as well as sex.

[3] Some people distinguish PLA from PRA in terms of the kinds of techniques used; others according to what the aims of the process might be and so on. By retaining a general category PRA/PLA, we recognise that each reader and contributor may interpret these terms differently.

analysis and action. Starting with the concept of vulnerability as central to effective HIV prevention, the article emphasises the need to go beyond individual behavioural change to address the complexities of HIV related vulnerability within communities. In a summary of a seminar on girls and young women and HIV, the UK AIDS Consortium raises issues that are central to SRH work more broadly. From vulnerability being rooted in inequalities, to strategies for engagement, to the need for advocacy at different levels to build accountability, their article also points to the need for an integrated and multi-dimensional approach to SRH.

Against this backdrop, the articles in this issue offer a rich array of ways of addressing issues of vulnerability at a range of levels and in a variety of contexts. All draw on participatory methodologies and many contribute new and innovative methods.

Creating space for voice

Highlighting both the centrality of gender and also the need to go beyond describing 'how things are' to analysing root causes, the article by World Neighbors and their programme partners describes practical tools for facilitating reflection and analysis on reproductive health issues in Nepal. Rull Boussen et al. (this issue) describe, how the use of PRA/PLA tools in needs assessment enhanced collaborative planning between NGOs, government and community members in Egypt. As in the Nepalese example, the authors describe the integration of PRA/PLA with methods from popular education, such as problem-posing sessions and root causes analysis. This facilitates moving beyond simply gathering 'voices' that describe how things are, to critical reflection on underlying causes to engage people as active shapers of how things might be.

Simasiku et al. focus directly on the vulnerability of young people, illustrating the use of PRA/PLA methods as an entry point for exploring sensitive issues with adolescents in Zambia. Kaim and Ndlovu also describe how such methods can be an entry point for a process that sought to engage young people in determining their needs and identifying solutions. Using the medium of a popular 'agony aunt' column in a Zimbabwean magazine suggested in initial PRA work, young people's own stories and experiences formed the basis for materials on SRH for use in schools. Kaim and Ndlovu's article highlights the importance of ensuring 'buy in' from a range of stakeholders for SRH work, illustrating the impact that the project had on changing relationships between students, teachers and community members. This is reflected in Kaleeba et al. (this issue) who show how an innovative School Health and AIDS Prevention programme has been enhanced by the involvement of parents, local government, religious leaders, youth representatives and health organisations through a District Level Steering Committee. Forder (this issue) also focuses on the gendered vulnerability of young people, in this case female Cambodian factory workers, where participatory methods have opened spaces in which voices can be heard.

Facilitating interaction and learning

Forder draws attention to the importance for facilitators to have dealt with some of their own issues around sexuality; yet the time and space to do so is often limited. She highlights some of the ambiguities that surround the role of the facilitator: when and whether to intervene, how to model behaviours that participants can feel freer to adopt and the ways in which the attitudes of facilitators may both block communication and be a perceived problem by participants. As Edstrom et al. and others also point out, skilled facilitation is of key importance in participatory SRH work. Yet what happens when organisational and other constraints make those skills scarce, as Shaw and Jawo, for example, demonstrate in the Gambian context? Hobbs and Simasiku address this issue, offering a pragmatic approach that seeks to

overcome some of the difficulties that can be anticipated.

Gordon and Phiri take up the question of facilitation involved in tackling some of the sensitive issues that surround SRH work. Echoing the point made by Edstrom et al. that information alone cannot change behaviour, their article describes the innovative use of a range of participatory methods in work with Zambian family planning Community Based Distributors (CBDs). These ranged from PRA/PLA to drama, to the use of pictures and stories, to non-directive peer counselling. They focus on the dynamics of interaction between and within groups of men and women, offering important lessons for the facilitation of peer and open group sessions. One important lesson from this insightful piece is the importance of recognising that while a neutral space may be created in the moment of an externally facilitated activity, once people return to their private spaces, things that are said and done in public may have serious repercussions.

Opening up dialogue

As Shaw and Jawo demonstrate, by making space for women and men to express their concerns, participatory processes can also begin to address vulnerabilities at a community-wide level. Shaw and Jawo's article, based on ongoing work in Gambia, describes the adaptation and use of 'Stepping Stones[4]', an interactive training process that brings drama, assertiveness training and visualisation together to open up dialogue between different gender and age groups. In this context, a positive association was found between participation in these activities and a reduction in wife beating, and raised awareness of risky behaviours associated with HIV and STDs.

Highlighting issues that resonate with many of the papers in this issue, Shaw and Jawo's paper describes some interesting innovations, both in terms of method and strategy. They emphasise safer sexual practices in the prevention of infertility as an entry point to preventive sexual health work. The authors describe innovations they used: from 'secret ballots' (see also Simasiku et al., this issue) and body mapping of 'turn ons' and 'turn offs'. As a similar illustration of how the flexibility of participatory methods offers scope for innovation and adaptation to the purpose and context, Butcher et al., (reprinted in this issue[5]) describe an innovative approach to condom promotion and evaluating peer education amongst sex workers.

Batchelor's article (this issue) takes body mapping a step further in its use to explore issues of desire, sensuality and body image with front-line health workers in the southern United States. All too often, discussions about sex are couched in terms of preventing diseases/pregnancy rather than in terms of pleasure and desire. What Batchelor's article so powerfully reminds us is that unless people are treated as people with emotional and sexual desires and needs, rather than as victims or vectors of disease, sexual health work can so easily fall into 'medicalising' the problem and missing the mark. Sturley's article is also an important reminder of the need to locate medical interventions, in this case vasectomy in Nepal, within the complexity of cultural meanings associated with their perceived and actual impact. Again the use of body mapping provided an entry point to exploring experiences that might otherwise have been ignored.

Building bridges

All too often, project evaluation marginalises the voices of those whom projects are designed to help, missing opportunities for building better relationships between agencies and those they work with. As Batchelor and Sturley's articles make clear, there is much to be gained from this interaction. Sellers and Westerby's article describes how young people and service providers came together in a participatory evaluation of sexual health provision. As well as

[4] See Welbourn, A. (1998).

[5] Reprinted from *PLA Notes* 33, October 1998.

detailing useful tools, and an innovation that has wider use in monitoring, the 'barriers wall', they demonstrate the value of participatory approaches in building bridges between service providers and users. Smith and Howson's account of participatory evaluation of CAFOD and partners' HIV prevention work in Southern Africa also contributes tools, such as the significant changes matrix, with the potential for building closer relationships between stakeholders. It also highlights the empowering aspects of this process for workers, as well as participants.

Making connections

Many of the articles in this issue make explicit the links between SRH and gender. Lewis' article provides a powerful example of a process that integrates a more subtle approach to gender. Aiming to build 'critical literacy about gender and power' with young people in Estonia, workshops integrated a range of levels, approaches and techniques: academic input with participant's own experiences, films and theatre with participatory drama, newspaper collage with young people's own messages and stories.

Lastly, Lynn et al., describe a process in the UK that made connections between the national and the local levels on a women's health issue that is a growing concern: breast cancer. This article demonstrates the links that can be built between advocacy and empowerment through a participatory process.

• Lessons learnt – we need to:

Why…

- Recognise that SRH issues touch all aspects of our lives and therefore the overall physical, material and psychological quality of our well being. Bad SRH can be both a cause and a result of a poor quality of life (Wanduragala – see Tips for Trainers, this issue).
- Acknowledge universally widespread gender violence, physical, sexual and psychological, and recognise that sexual and reproductive health is a human rights issue...

Who…

- Work with boys and men as well as girls and women.
- Don't put people in 'boxes' and label them as 'heterosexual' or 'homosexual' but work with their own self-definitions, their own experiences and identities.
- Acknowledge the importance of gaining support from gatekeepers and the opportunities of making them 'champions' of change; include parents, teachers, religious leaders, community leaders, government officials etc.
- Acknowledge that young people are often sexually active before parents and others realise (or want to accept) and that they are at risk through lack of information and support
- Build on the clear evidence that good sex education for young people, which also includes relationships, assertiveness and communication skills, delays the onset of sexual activity and makes it safer when it starts. Denying young people access to information is to deny them the right to have safer sex and reduce their vulnerability to infection and pregnancy
- Acknowledge that young women are particularly vulnerable to infection and exploitation
- Recognise that ordinary people, if given the right support, are quite capable of developing their own workshop material.
- Don't forget that older people have sexual health concerns, both related to the life-course (such as menopausal and impotence symptoms) and as part of a wider adult population (such as STIs, HIV and AIDS)

How…

- Recognise that there is a need for active collaboration and co-operation between different agencies and institutions at different levels of the

system, e.g. youth friendly clinics, sex worker-protective laws.
- Always include gender awareness as part of processes designed to bring about changes in attitudes and behaviour towards SRH issues.
- Recognise that 'gender' is not simply a 'women's issue' and that strategies may be needed for enabling men to address their gender issues and SRH needs *as men.*
- Create opportunities for trainers/facilitators to process and internalise issues for themselves before facilitating/training others.
- Make spaces for people to work in peer groups as well as to come together in open sessions; recognise the importance of working sensitively with this structure to ensure confidentiality and positive outcomes.
- Be open to new methods of learning: PRA, drama/role-play and assertiveness.

What…

- Avoid blueprints: adapt existing materials or develop new materials to suit the cultural and social settings in which SRH work is done.
- Recognise the range of levels/contexts in which participatory activities can make a difference; from work with local communities and particular interest groups, to work with health, education and social care workers to work on national policy issues and campaigns.

Where…

- Start from where local people are; e.g. infertility, rather than STIs, unwanted pregnancies rather than HIV etc.

- **Andrea Cornwall,** Research Fellow, IDS, University of Sussex, Falmer, Brighton, BN1 9RE, UK. Tel:+44 (0) 1273 606 261; Fax: +44 (0) 1273 621 202; Email: A.Cornwall@ids.ac.uk, **and Alice Welbourn,** Consultant. Email: padbourn@aol.com**;** c/o IIED, 3 Endsleigh Street, London, WC1H 0DD, UK.

ACKNOWLEDGEMENTS

We'd like to thank all the people who sent us materials for this issue that we were unable to include. Andrea Cornwall is grateful to DfID, Sida and SDC for their support to the Participation Group at IDS which made her work on this issue possible.

REFERENCES

Gangakhedkar R.R., Bentley M.E., Divekar Anand D. 1997: "Spread of HIV infection in Married Monogamous Women in India" in Journal of the American Medical Association *Vol.278.*

Heise L., Ellsberg M. and Gottemoeller M. 1999: "Ending Violence Against Women" Population Reports vol XXVII, No. 4. Series L, No. 11. Johns Hopkins Center for Communication Programs and CHANGE, Baltimore.

Hunter S. and Williamson J. 1998 Children on the Brink. Strategies to support children isolated by HIV/AIDS, USAID, Washington.

Kaleeba N., Kadowe J., Kalinaki D., and Williams G. 2000 Open Secret: Facing Up To HIV and Aids In Uganda Strategies for Hope Series No. 15, Strategies for Hope, Oxford.

Kaul Shah, M., Zambezi, R., & Simasiku, M. (1998) The use of PLA Methodology in partnership for adolescent sexual and reproductive health (PALS): a field guide. CARE International

Martin S.L., Kilgallen B., Amy Ong Tsui, Kuhu Maitra, Kaushalendra Kumar Singh, Lawrence L. Kupper, 1999 *Sexual Behaviors and Reproductive Health Outcomes Associations With Wife Abuse in India,* Journal of American Medical Association, Vol.282: 1967-1972

UNAIDS Press release 23 November 1999 London

Welbourn, A. (1998) Gender, participation and HIV: a positive force for change in Guijt, I.& Kaul Shah, M. (Eds) The Myth of Community. IT publications

4

Ain't misbehavin' : beyond individual behaviour change

Jerker Edström with Arturo Cristobal, Chulani de Soyza and Tilly Sellers

• Introduction

The International HIV/AIDS Alliance supports 'linking organisations' in various developing countries which, in turn, support local non-governmental organisations (NGOs) to carry out HIV/AIDS activities with local communities. Such linking organisations include HIV/AIDS/STD Alliance Bangladesh (HASAB), the Philippine HIV/AIDS NGO Support Programme (PHANSuP), Alliance Lanka in Sri Lanka and the Khmer HIV/AIDS NGO Alliance (KHANA) in Cambodia. As linking organisations started mobilising community groups to respond to AIDS in their respective countries (in the mid 1990s) they found that the majority of NGOs wanted to continue to focus, often exclusively, on basic information provision (such as awareness seminars).

However, experience and accumulated evidence has shown that information, education and communication (IEC) alone is often insufficient to bring about sustained behaviour change, or substantially impact on people's ability to protect themselves from HIV infection. This might have to do with the fact that many IEC initiatives were either technically weak or socially inappropriate, or both. However, a fuller explanation is likely to be that many programmes lacked strategies beyond awareness raising, or focused merely on individual 'behaviour change', which brings us to our starting point.

• 'Ain't misbehavin' – what's your problem, anyway?'

We should start by noting a range of factors, which also influence an individual's risk of infection, but are not directly related to her/his behaviour. Some obvious examples would include:

- access to risk/harm reducing technology, such as condoms or clean needles;
- power of the individual to make her/his own choices;
- elevated biological vulnerability to infection; e.g. as a result of having a pre-existing Sexually Transmitted Disease (STD);
- infection levels within the broader community and partners; and
- lack of knowledge of own or partners' HIV sero-status (i.e. whether infected or not).

Whilst there are certain behavioural aspects to some of these 'problems' and some themselves present obstacles to behavioural adaptation, it is not useful to describe them as mainly 'behavioural' issues. Each problem listed can be addressed with dedicated or combined strategies, which are not only awareness raising or behaviour change strategies. Indeed, there is a whole range of types of valid strategies beyond awareness raising or behaviour change communication (see Figure 1).

• Shifting the primary focus to vulnerability

By shifting our focus away from the behaviour of individuals and concentrating on HIV related vulnerability within communities, the *communities themselves* are more likely to be able and willing to help *us* identify relevant and effective responses.

Vulnerabilities may involve factors both independent of behaviour and factors underlying behaviour, which are often more

important to address than the behaviour itself, (see Figure 2). Whether a particular vulnerability affects risk of infection independently of behaviour or presents an underlying obstacle to behaviour change, the point is that it is the real vulnerabilities that are important to address primarily.

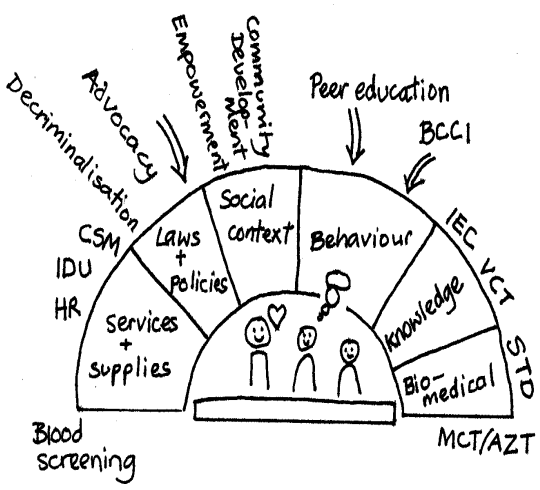

Figure 1. Examples of types of factors affecting likelihood of HIV infection, and related types of strategies to affect change

IDU,HR = harm reduction (HR) strategies for injecting drug users (IDU); CSM = Condom Social Marketing; BCCI = Behaviour change communications interventions; IE&C = Information, education and communication; VCT = Voluntary counselling and testing (for HIV); STD = treatment of sexually transmitted diseases (here); MCT/AZT = Reduction of mother-to-child transmission through treatment of pregnant women with AZT (anti-retroviral for HIV infection).

Rather than working as outsiders coming in to solve the behavioural problems of 'the locals', it is crucial to recognise that the sources of HIV related vulnerability tend to be very complex indeed at the local level. It is when *those* vulnerabilities are mitigated that people can respond to knowledge and information.

Addressing vulnerability through participation and empowerment

It is primarily as a result of this realisation that the Alliance has turned away from asking the 'experts' for the answers and turned to local communities themselves. From 1996 onwards, we have increasingly focused on using a more flexible approach, with a 'tool bag' of both participatory methods and processes. These include tools and approaches used in Participatory Rural Appraisal (PRA), or participatory action and reaction, which may be a more appropriate phase, since it better encapsulates the application of participatory methodologies in sexual health, in different types of activities and in different contexts.

The key components of the 'tool bag' include social maps, discussion groups, Venn diagrams, ranking and scoring, body mapping, causal analysis flowcharts, life-lines, historical time-lines, trend diagrams, income and expenditure charts, and HIV wheels (where vulnerabilities are identified as segments in a pie chart, and filled in according to their significance) etc. These 'tools' have been used by, or with, community members to describe and analyse the issues of concern to them, and to explore how those issues link to sexual vulnerability and HIV/AIDS. This has enabled local grassroots NGOs to actually involve community members in all stages of projects; community assessments, project design, implementation and monitoring and evaluation.

Figure 2. Some causal flows between community factors, behaviour and infection risk

The mere use of participatory tools *can* cause shifts in perceptions as well as spark off participatory processes in different ways. However, the tools are no guarantee for success by themselves. Their effectiveness also relies on skilled facilitation, as well as on adopting enabling processes and frameworks.

Participatory community assessments formed a starting point for longer interactive processes, where project responses were jointly identified and tried out, then reviewed in order to revise project strategies and approaches. The important point was to adapt the process to the capacity and situation of the local NGOs and their communities, in order to allow for effective participation.

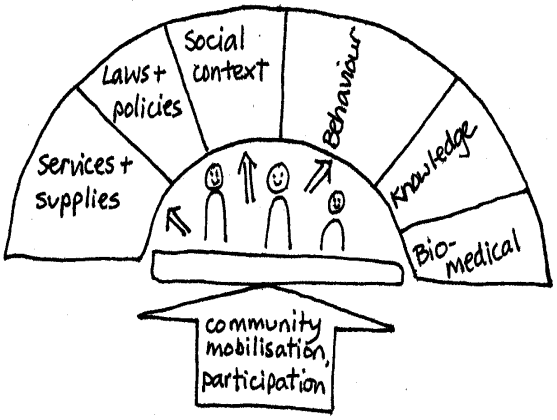

Figure 3. Capacity building to support participation in community assessments and designing responses to HIV/AIDS vulnerability

• Examples of community-identified strategies responding to HIV/AIDS

The following section describes a range of different types of ways in which local NGOs have been helped to address HIV/AIDS related vulnerability and move beyond awareness raising or individual behaviour change.

Addressing social contexts and peer norms in participatory group work

As a result of the increasingly participatory approaches used in supporting NGOs to carry out community assessment in different countries, a natural development has been for many NGOs to start to develop strategies for responding to AIDS with group activities, also using participatory techniques in the process.

One example of this is the work of Rajarata Sahabagitha Padanama, in Sri Lanka, which now uses a very participatory and gender sensitive group work approach to peer education and condom promotion/distribution. The organisation now has a very effective programme, which supports the community in facing the challenges identified by them. Even the local government health worker seeks support from the leaders to reach and support the community.

Such group work can be particularly effective in gender specific groups of similar ages and they can help women or men explore their own issues, attitudes and options, whilst learning about HIV/AIDS and STD through working together.

Addressing people's vulnerability by working with other sexual partners

In some cases, however, it can be harder to help community members respond to their own vulnerability without also working with other groups who may be sexual partners from outside the community, who are away for long periods or who may be harder to reach in the same way as described above.

In Cambodia for example, certain environmental factors, such as conflict and the presence of armed personnel etc., limit the capacity of local young women and men in putting their knowledge and skills (in safer sex) into practice. NGO project staff and volunteers in some communities work on these 'other' factors, rather than merely on the skills of the local young women and men themselves. Kasekor Thmey and the Khmer Buddhist Association (KBA) are two NGOs now working with young police and soldiers to

reduce their vulnerability to HIV/STD infection, as well as that of the young women in the community. They do this by working with the uniformed men to explore their own knowledge and attitudes on sexuality and on condom using skills, as well as by negotiating with senior officers to increase access both to condoms and to STD services.

Conversely, it can be useful to work with local sexual partners of mobile people in order to obtain access to an otherwise hard-to-reach group. In the Philippines, for example, overseas Filipino contract workers are a group of people considered to be at high risk of HIV infection. This is a result of higher risks of exposure to HIV when away from their families for long period and working in other countries in the region. One local NGO, Kaaraydan, who mainly support male Overseas Filipino Workers (OFWs) and their loved ones, designed a very simple but innovative project. Kaaraydan has developed, designed and provided partners with stationery, aerograms and postcards to enable the loved ones to write letters to their OFW partners. Furthermore, on the stationery are statements and captions about HIV/AIDS. As a central part of the project, Kaaraydan has also been conducting participatory group discussions in the communites of the loved ones of OFWs, which has helped them explore and understand the plight of the OFWs abroad, why sexual relations outside of the primary 'home' or partnership occurred etc.. They learned how loneliness may put OFWs at particular risk and that communiction is very important to their OFWs, which is why the strategy of supporting letter writing was developed. As a result, the loved ones, especially those married to OFWs are now able to negotiate for condom use with their OFW partners or husbands when at home and 'encourage' them to reduce sexual risk when abroad.

Addressing gaps in service provision

As NGOs have developed stronger responses to HIV/AIDS in their communities, a fairly common theme has been to find ways of improving community members' access to services, such as STD treatment, and supplies of condoms.

As mentioned briefly, several NGOs, supported by HASAB in Bangladesh, developed clinical STD service components of their HIV/AIDS projects, in response to community felt gaps in government service provision. One NGO, Assistance for Slum Dwellers (ASD), found it challenging to conduct both effective participatory outreach work and provide quality clinical services, but instead broadened their review and assessment approach to include a wider range of stakeholders, allowing them to develop more strategic partnerships. In particular they were now able to refer community members to the clinic of another HASAB partner NGO, Al-Fallah. This allowed them to help bridge the service gap whilst also focusing their energies on working more closely with their communities.

Addressing other contextual factors and linking those to HIV/AIDS

Aside from working on the most directly relevant factors of vulnerability to HIV, many NGOs have also worked with community members to either address broader contextual factors, such as discrimination, or used meeting community needs for recreational facilities or income generation schemes as entry-points for education, services and discussion on HIV/AIDS and STD.

For example, the NGO, Association of Farmers Development (AFD) in Cambodia, works with their rural poor community in many ways to meet their different needs, placing HIV prevention into the broader context of the community. Aside from a range of reproductive health work with both women and men, AFD also supports a women's income generating group (funded from other sources) and links the two projects to organise drama performances, using both for opportunities to have in-depth discussions about sexuality and sexual health.

Whilst poverty, for example, is often identified as the contextual root cause of most vulnerabilities, it is not always possible or realistic to try to impact on HIV by focusing scarce HIV/AIDS resources on, for example, income generation.

On the other hand, where NGOs are closely involved with their communities in addressing various aspects of their lives with different projects, it is often useful to draw strategic links between these to gain access to and time with a particular group. It can also be useful to make the HIV/AIDS work more relevant to the more keenly felt needs of communities.

Mobilising and empowering marginalised groups

To go even further, some NGOs have focused on mobilising and empowering marginalised groups such as gay men, drug users or sex workers. Such projects usually need to address a broad range of the needs of these groups to be truly effective, since their needs tend to be closely interlinked with their vulnerability to HIV/AIDS.

For three years now, PHANSuP in the Philippines has funded an NGO called IWAG Dabaw to run a centre for gay men in Davao, where the gay community can make use of its services including:

- counselling;
- a resource centre;
- STD referrals that include subsidy provision for the medicine; and
- a venue for activities, such as small group discussions on relevant issues, stepping stones sessions, film showing, condom distribution, etc.

This is a very innovative project, as the gay men have developed a sense of ownership of the project. The centre also helped them develop their self-esteem as it provides a place where they can go freely and be themselves, without the fear of either being discriminated against or abused. As the importance of the centre was enhanced by the project, gay men themselves established other such centres in the communities. These served as a 'local response' to the needs of the gay men and other stakeholders (e.g. gay men's parents, lovers, police, local executives and others).

One NGO in Bangladesh named SHEASS identified strategies for harm reduction among injecting drug users as a priority. SHEASS addressed this through involvement in outreach work and awareness raising on issues such as risk reduction, sexuality and STDs, and HIV/AIDS. Local leaders and members of the broader community were mobilised to help fight discrimination within the community. A drop-in centre providing a wide range of services for injecting drug users and their families, including needle exchange, condom distribution and education about general health, HIV/AIDS and harm reduction, was also established.

Not all NGOs are well placed to mobilise and empower marginalised groups, as this work requires excellent contact and credibility with the community in question. Offering practical services, as shown by the work of SHEASS and IWAG, can help to gain that trust and respect. Often, however, fundamental shifts in the perceptions and attitudes of NGO workers themselves are needed for this and, although participatory training and skills can help this, it does not take away the need for other skills and understanding of the deeper issues in relation to the particular community in question.

Ten lessons learned

- Behaviour is not the only relevant variable as a core-problem affecting vulnerability to HIV; nor is it the only, or even necessarily the main, factor to address.

- Vulnerability as a concept forces us to adopt a context-specific approach to situation and problem analysis.

- Vulnerability needs to be understood as being complex and working in different ways, through behaviour and independently of behaviour.

- A participatory bottom-up approach allows for more appropriate identification of the complexities of vulnerability; jointly 'owned' responses and project solutions with communities; better dynamics between NGOs and their communities, as well as mobilisation of members to work together for the changes required.

- Drawing a distinction between 'contextual' and 'linked' interventions is useful for understanding how certain

AIDS strategies beyond awareness raising or behaviour change deal with vulnerability to HIV and broader community issues.

- Participatory facilitation requires considerable skills and capacity building, but good facilitation of these processes also requires good HIV/AIDS skills.

- The process needs to be honest and sensitive, but firm in guiding assessments and reviews towards HIV vulnerability rather than ending up focusing on any community issues.

- There is often a need to purposely design and sequence the assessment process to involve particularly marginalised or at risk groups from early in the process.

- Scaling up capacity building and participatory processes may in fact be more important than scaling up 'intervention packages'. It is a common mistake to assume that it is the resulting strategies which primarily need scaling up to achieve an impact, when successful strategies usually derive their success from the process adopted.

- The first and most important attitudes and behaviours to address in good HIV/AIDS work are our own (as health, development and NGO workers).

- **Jerker Edström,** Regional Co-ordinator: Asia, International HIV/AIDS Alliance, 2 Pentonville Road, London, N1 9HF, UK Tel: +44 (0) 20 7841 3500; Fax: +44 (0) 20 7841 3501; Email: jedstrom@aidsalliance.org. ; **Arturo Cristobal,** Programme Manager, Philippines HIV/AIDS NGO Support Programme (PHANSuP), Mezzanine Brickville Condominium, 28 North Domingo Street, New Manila, Quezon City Philippines, **Chulani de Soyza,** Centre for Development Services, 35/5 Horton Place, Colombo 7, Sri Lanka , and **Tilly Sellers,** Technical Adviser:Cambodia, International HIV/AIDS Alliance, c/o Khmer HIV/AIDS NGO Alliance (KHANA), #13 Street 302, P.O. Box 2311, Phnom Penh 3, Cambodia.

Further information is available on this work from the International HIV/AIDS Alliance, 2 Pentonville Road, London, N1 9HF, Uk. Tel: +44 (0) 20 7841 3500; Fax: +44 (0) 20 7841 3501; Email: jedstrom@aidsalliance.org

5

Seminar on HIV and girls and young women, November 1999, London

Report compiled by the Working Group on Children and HIV; UK NGO AIDS Consortium

• Introduction

The working group on children of the UK NGO AIDS Consortium held an international seminar recently in London on the vulnerability of female children to HIV/AIDS. The UK NGO AIDS Consortium is a group of UK based organisations who work together to understand and develop effective approaches to the problem of the HIV epidemic in the South. It enables each agency to share its experiences and help all the members improve their responses to the epidemic. The Consortium represents 50-55 UK-based development organisations working with HIV/AIDS issues in all parts of the world.

This seminar was organised in response to growing concern around the world about the impact of HIV/AIDS on young people and, in particular, the differential effect it appears to be having on girls and young women. According to estimates by UNAIDS, 60% of new infections occur among young people. However, data disaggregated by sex also shows that girls have consistently higher rates of infection than boys do. This is due to the greater social and biological vulnerability of girls to HIV/AIDS. While both boys and girls are vulnerable to sexual coercion, girls appear to be more often victimised by sexual abuse and exploitation because of their gender.

The seminar was therefore designed to address issues related to the vulnerability of girls to HIV/AIDS and was concerned in particular with sexual abuse, exploitation and violence. It brought together practitioners and advocates from around the world who shared their experiences and came up with recommendations to improve service delivery and advocacy. Speakers and participants came from a wide range of organisations and countries, representing Africa, Asia, Latin America, Europe and the USA. A number of cross-cutting themes emerged from the seminar which underline many of the concerns raised by practitioners from around the world. These emphasise how the experiences of girls from around the world are universal.

Some of the major themes

- Deepening poverty, structural and social inequalities are some of the major causes of girls' vulnerability to HIV. For example, girls living in poverty and with limited opportunities for education and income may resort to selling sex in order to survive.
- Unequal power relationships based on gender and age provide the context in which abuse takes place.
- Apart from economic needs, girls fall into relationships with men to meet their need for protection, affection and love.
- The social isolation of girls also serves to increase their vulnerability to sexual victimisation and HIV.
- A silence surrounds the issue of sexual abuse, which makes it difficult to identify and address.
- Some cultural traditions and attitudes often provide a sanction for abuse and represent some of the greatest challenges to NGOs.
- A major barrier to the advancement of women and girls is the support that still exists for traditional gender roles. Without a critical mass of women involved in the decision-making process, changes are likely to occur slowly.
- A lack of political will exists to enforce laws and principles adhered to in international conventions. NGOs have an important role to play in advocating for the implementation of conventions such as the

Convention on the Rights of the Child (CRC) and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

- **Recommendations for service delivery and advocacy**

Some key principles

Programmes need to address the social and political environment in which girls live, but also the psychological causes and effects of abuse and vulnerability to HIV/AIDS.

As explained by Randini Wanduragala of World Vision, an integrated approach seems to work best. An example of this approach is demonstrated by Plan International India, which organised a programme in collaboration with an NGO in India and Nepal to return Nepali girls to their homes who were sold into prostitution in India. After girls were rescued from the brothels, they were taken to centres where they received counselling and medical care. Counselling was given to girls as well as their families at every stage of the process. Activities were also organised to provide basic literacy skills and training in various trades so that girls might find alternative sources of income. Once back in their communities, girls continued to be supervised but were also provided with credit assistance to start small income-generating projects.

In addition to re-integration, the programme also included a focus on prevention. ABC Nepal, the NGO counterpart in Nepal, organised activities in communities to raise awareness of the problem of trafficking and HIV/AIDS. One important outcome was the formation of 'pressure groups', made up of individuals from different sections of the community, who have implemented their own activities with financial assistance from the project. Some of the activities of pressure groups include street drama, rallies, public forums, and lobbying of local government to encourage the arrest of traffickers.

Change is possible if we start with women and girls as the catalysts for change.
Thoko Ngwenya of The Musasa Project in Zimbabwe explained that their 'interventions with women centre on the individual woman so that she can focus on her needs and become aware of her abilities, decrease victim behaviour and develop an awareness of the socio-political context of the violence she has suffered'. Each woman is treated as the best expert in dealing with her situation and decides what she wants to do with her life. The goal is to encourage her to build her self-confidence and eventually regain control over her life and circumstances. The centre provides counselling but also training on HIV/AIDS, communication and assertiveness, and gender. After six months in the programme, noticeable changes were found among women who were assisted.

Programmes need to provide an environment that raises the possibilities for girls and enables them to change their lives positively.

As Judith Musick of the Ounce of Prevention Fund explained, 'those working with disadvantaged girls cannot break the hold of their difficult or toxic life circumstances without serious, sustained efforts to expand girls' horizons and increase their knowledge and skills'. Girls need to be exposed to other possibilities and given the chance to exceed their own expectations. This could consist of social activities (i.e. drama, arts and crafts, sports or social activism) and/or non-formal or professional education. Judith Musick also pointed out that in working with girls who have been sexually abused or exploited it is important to remember that, as children, they will have needs and interests that are similar to other children their age. Programmes should not just focus on their sexuality, but encourage other activities that girls may be interested in, such as sports or drama.

- **Other recommendations for NGOs**

General

- Involve children as decision-makers in programmes and provide opportunities for them to become their own advocates.
- Follow a participatory approach to planning, implementation and evaluation.
- Approach the issues from a rights-based perspective, e.g. defending the right of children to be protected from violence and

abuse as fundamental human rights principles.
- Use mentors or alumni in programmes as teachers. Girls need positive role models who can show them other possible futures.
- Carry out research to inform planning, especially the collection of disaggregated data.
- Document and share experiences with other NGOs. In particular, examples of good practice or successful programmes should be disseminated.
- Ensure sufficient quality of care in service provision.

International

- Make governments accountable to the UN conventions they have ratified to accelerate their implementation.
- Integrate programmes into the wider development framework to address the larger causes such as poverty and structural inequalities. For example, lobbying government or donors to increase the allocation of resources to HIV/AIDS programmes and education.

National

- Strengthen partnerships with the private sector, trade unions and the media. Journalists and media institutions can be valuable allies in making issues known to policy-makers and the wider public. Trade unions and private corporations may also provide important material and moral support for causes.

Regional

- Challenge cultural attitudes to create an environment that does not tolerate violence, abuse and exploitation. Organisations need to work continuously with the public to shift attitudes, and while this may take time, change is possible, as examples in changing attitudes to Female Genital Mutilation have shown (where negative aspects have been discouraged while positive aspects, such as puberty rites, are maintained).

Local

- Mobilise all sections of the community to raise awareness of the issues. A greater focus is needed on men's and boys' involvement and awareness in particular.

Recommendations for strengthening advocacy include:
- research to find out what is being done, to link up with organisations and to know what resources/information are available;
- developing 'strategic' alliances with other organisations and agencies (i.e. government, social service agencies and law enforcement may be particularly useful to make sure that issues are dealt with and services reach girls that are appropriate and gender-sensitive);
- strengthening partnerships with other NGOs and networks;
- investigating points of entry which can be approached to have an influence on policy in government or international institutions.

To contribute to raising awareness at the local and international level, organisations should look for and use every opportunity available to raise the issues onto the agenda. This means informing individuals within our own organisations as well as outside. With this objective in mind, the Consortium is hoping to maintain contact with agencies who were involved in the seminar and others concerned with the impact of HIV on children and girls to keep these issues high on the agenda and to make they are raised at relevant international fora and debates (i.e. the upcoming international conference on HIV/AIDS in Durban and Beijing +5, which is the follow-up to the UN Fourth World Conference on Women held in Beijing in 1995).

- **The Working Group on Children and HIV,** UK NGO AIDS Consortium**,** 37-39 Great Guildford Street, London, SE1 0ES. UK. Tel: +44 (0) 20 7401 8231; Fax: +44 (0) 20 7401 2124; Email: ukaidscon@gn.apc.org

NOTES

A fuller report of the seminar is available (February 2000). For more information, please contact the Consortium at: ukaidscon@gn.apc.org

6

Helping NGO staff (& then community groups) analyse reproductive health & gender issues

Developed with World Neighbors programme partners in Nepal

• Background

World Neighbors has teamed up with national and local non-government organisations (NGOs) in rural development efforts in Nepal since the initiation of its programme there in 1972. From the beginning, World Neighbors programmes in Nepal have included strong family planning and primary health components, along with agroforestry, livestock and assistance in the construction of drinking water systems. Our strategy has long been focused on strengthening local, community-based groups to implement and manage these integrated efforts.

One of World Neighbors' first partnerships in the region was with a project of the Family Planning Association of Nepal (FPAN), the Baudha Bahunipati Family Welfare Project (BBP). BBP responds to communities' expressed needs with an integrated set of initiatives, including, among others, improved livestock health, safe drinking water, women's group formation, and access to primary health care and family planning services. Evaluations of the programme indicate that marginalised communities with three to four years of association with BBP have shown contraceptive prevalence rates approaching double the national average.

Assessments of women's savings and credit groups involved in the programme revealed that some of the groups were making loans for health referral costs , up to 15 percent of loans in some groups, indicating a greater demand for health services than expected. The time seemed right to conduct a comprehensive, in-depth assessment to determine women's health concerns and develop some strategies to address these needs.

• Assessment & action

In March-April 1996, a Reproductive health Needs Assessment was conducted that has been a key part of the institutional and programmatic learning process. Based on the findings of this assessment, a 'Training of Trainers' (TOT) workshop for NGO staff was convened in March 1997, facilitated by the BBP advisory support team. Objectives of this workshop were:

- to enable participants to better understand reproductive health from a gender-sensitive perspective;
- to help participants analyse their current activities in terms of an reproductive health/gender approach;
- to build skills in facilitation and the use of participatory tools; and,
- to develop an action plan for working with NGOs and women's savings and credit groups.

The participatory methodology used during this workshop was created and adapted based on the content of the Needs Assessment and in keeping with the principles of participatory learning or PRA. Participatory exercises were repeated numerous times during the workshop to enable the participants both to explore new ideas about reproductive health and gender as well as to become more comfortable facilitating the exercises for their own future fieldwork

Training format

The workshop was designed to generate ideas on how to address reproductive health and gender issues at both the NGO level and with women's savings & credit groups at the community level. Review exercises were used

both to revise plans and to reinforce the participants' understanding of the material covered. Participants also worked in teams to develop an action plan, including making decisions about with whom they would work, when, what would be done and using what tools. Evaluations were conducted at the end of each day and at the end of the workshop.

• Tools & exercises

The 15 exercises developed for the TOT workshop can be organised into the following categories, based on their primary purpose.

- Identifying reproductive health and gender issues and problems
- Analysing reproductive health and gender issues and problems
- Prioritising
- Planning

In this article, we focus on the tools that were developed and employed to analyse reproductive health and gender issues and problems. These exercises include:

- problem trees;
- root/consequence analysis: social context versus medical/services context;
- root/consequence analysis: gender differences; and
- root/consequence analysis: weighting the gender differences

They are designed to identify and analyse the causes and consequences of reproductive health problems. While we only present one example of each exercise, all of these tools can be used to examine both the root causes and the consequences of reproductive health related issues.

It is important to remember that the exercises were designed for the particular context and needs of the Nepali NGOs participating in the TOT. They can, however, be useful to development practitioners in other situations if they are shaped and adapted to the specific needs and objectives of the participants.

Problem trees

Objective: To identify the causes and consequences of specific reproductive health problems.

Materials needed: Posters with a sketch of a tree showing both its roots and bare branches, blank cards (three colours).

Procedure: Participants analyse the causes and consequences of reproductive health problems, using the image of a tree's roots, trunk and fruit. The trunk of the tree represents the problem being discussed, the roots represent the causes and the fruit symbolise the consequences.

1. Ask the participants to name a reproductive health related problem faced in the communities with which they work. Write this problem on a card (colour A) and tape it to the trunk of the first tree diagram.

2. Brainstorm with the group on the causes of the problem being discussed. Write each cause on a separate card (colour B) and tape them to the root area of the diagram.

3. Now brainstorm with the group about the consequences of the problem. Again, write each answer on a separate card (colour C) and tape them on the branches of the tree.

4. The first problem tree is examined and discussed by the whole group, followed by small group work on other problem trees.

5. Assign a letter or number code to each problem, and then code the roots and fruit cards with their corresponding Problem Trees (e.g. AF1 etc.).

6. The results of all the small groups are displayed, and participants take a 'walk through the forest' as groups present their problem trees to one another.

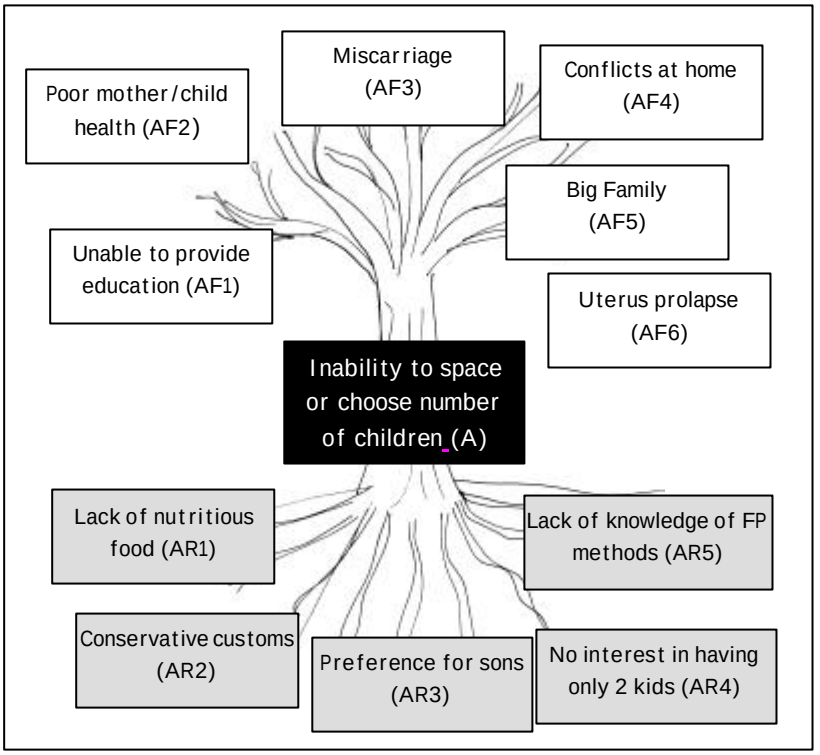

Figure 1. Example of a problem tree

Workshop experience

Workshop participants 'grew' 15 Problem Trees, addressing both 'biomedical' (e.g. access to family planning services) and 'social' (e.g. violence against women) issues. Figure 1 shows the tree generated from a discussion about spacing children.

After the participants generated and presented their Problem Trees, they formed 'training triangle' groups to simulate facilitating the preparation of such trees with other groups. In a three-round rotation session, each group member served as facilitator, participant and observer.

• Root analysis: social context versus medical/services context

Objective: To analyse the root causes of reproductive health problems in terms of the context in which they originate and in which they may best be addressed: either medical, social or both.

Materials needed: The completed, coded root cards from the problem trees, a 3-column matrix prepared on the floor or table. Column headings are visual representations of a social context (a village scene), a medical/services context (a clinic) and, in the middle, a mix of both (a village and clinic in one picture).

Procedure: Participants mix the root cards from the various problem trees and sort them into the three categories.

1. Explain the three categories represented on the matrix and confirm that the participants have a clear and shared understanding.

2. Demonstrate sorting a few root cards into the three columns.

3. All the participants then work together to sort the root cards, first finding any repeats and then placing the cards on the matrix according to their domains.

Code each card with its appropriate context category (i.e. (M, M/S and S)

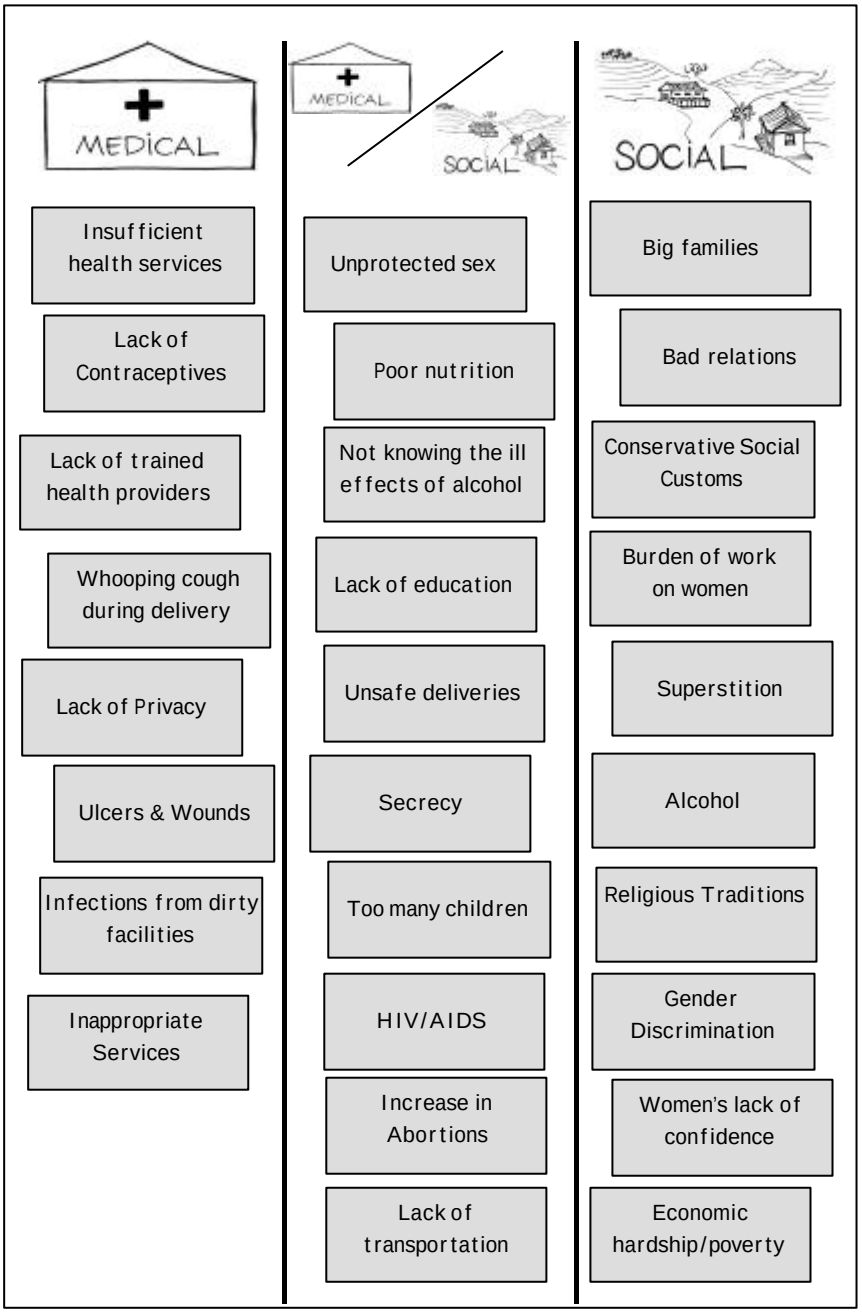

Figure 2. Example of root analysis: social context versus medical/services context

Workshop experience

Once all the root cards were sorted on the matrix, the participants reflected on the results. It was observed that Medical/Service issues were what they usually thought about and dealt with in their programmes, whereas the Social Context issues were generally not intentionally or systematically addressed. Also, it was noted that there were many similar roots across the different problem trees, indicating that different problems have similar underlying causes.

- **Consequence analysis: gender differences**

Objective: To analyse the consequences of reproductive health problems in terms of their differential effects on men and women.

Materials Needed: The completed, coded consequence cards, a 3-column matrix prepared on the floor or table. Column headings are visual representations of a woman only, a man only and, in the middle, a man and a woman together.

Procedure: Participants mix the consequence cards from the various problem trees and sort them into the three categories.

1. Explain the differences between the three columns and the objective of the exercise.

2. Demonstrate sorting a few cards from different problem trees into three columns, according to those that affect women only, men only and both.

3. All the participants then work together to sort all the consequence cards, first clustering together all the repeats and then placing the cards on the matrix according to gender implications.

4. Code each card with its appropriate gender category (i.e. F, F/M or M).

Workshop Experience

When the workshop participants categorised their consequence cards, almost all of the cards were placed in the middle column, indicating a shared impact on both men and women.

Here is a partial list of the participants' identified consequences and how they categorised them.

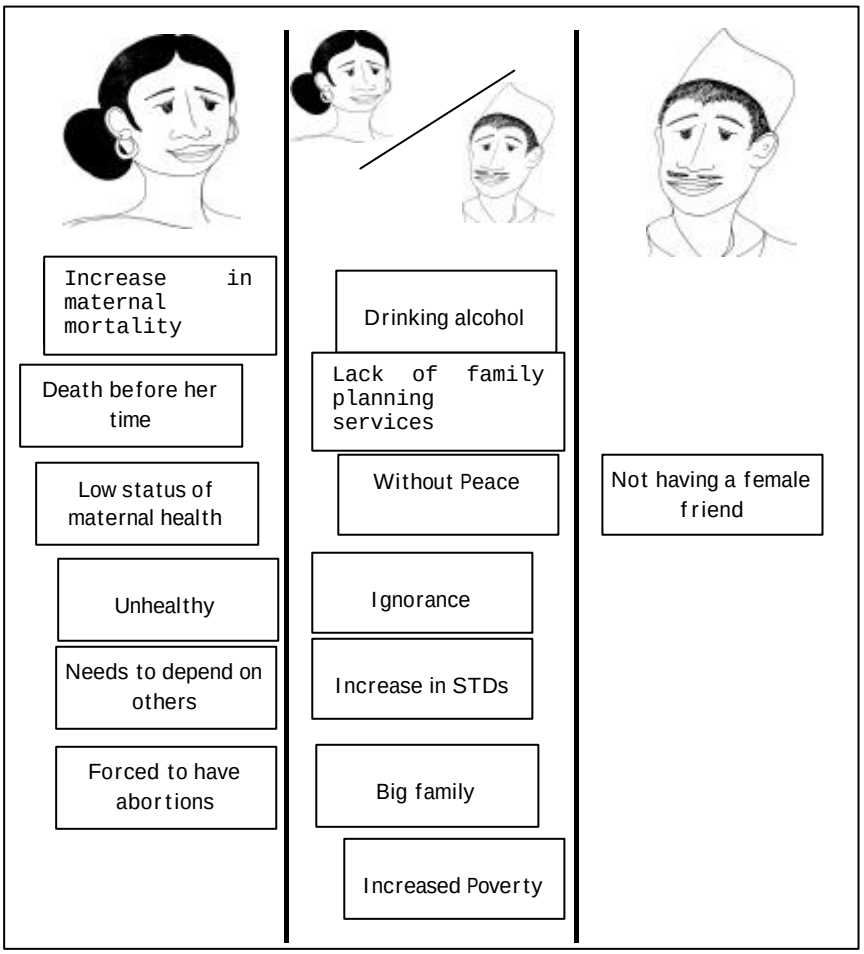

Figure 3. Example of consequence analysis: gender differences

- **Consequence analysis: weighting the gender differences**

Objective: To analyse more deeply the gender differences regarding specific reproductive health problems.

Materials needed: The same three-column matrix used in the Gender Differences exercise, the completed, coded consequence cards from the centre column (those affecting both men and women) and 10 beans or small stones for each card.

Procedure: Participants use the beans or stones to weight the relative impact of each consequence on men and women.

1. Remove the consequence cards from the 'Men Only' and 'Women Only' columns of the matrix. Leave the cards in the centre column.

2. Explain to the participants that they can distribute 10 beans or stones for each consequence between the Men and the Women columns. This distribution should demonstrate what proportion of the impact is experienced by women and by men. For example, if the impact is shared equally, they would put 5 beans or stones on either side of the card.

3. Demonstrate weighting a few consequences with the full group.

4. All the participants then work together to weight remaining consequence cards.

5. Once the beans have been distributed, write the 'votes' on each consequence card (i.e. M3/W7).

Workshop experience

The participants found that this exercise allowed them to analyse more accurately the differences in impact based on gender. For example, while lack of family planning services affected both men and women, the issue was seen to have a significantly greater impact on women.

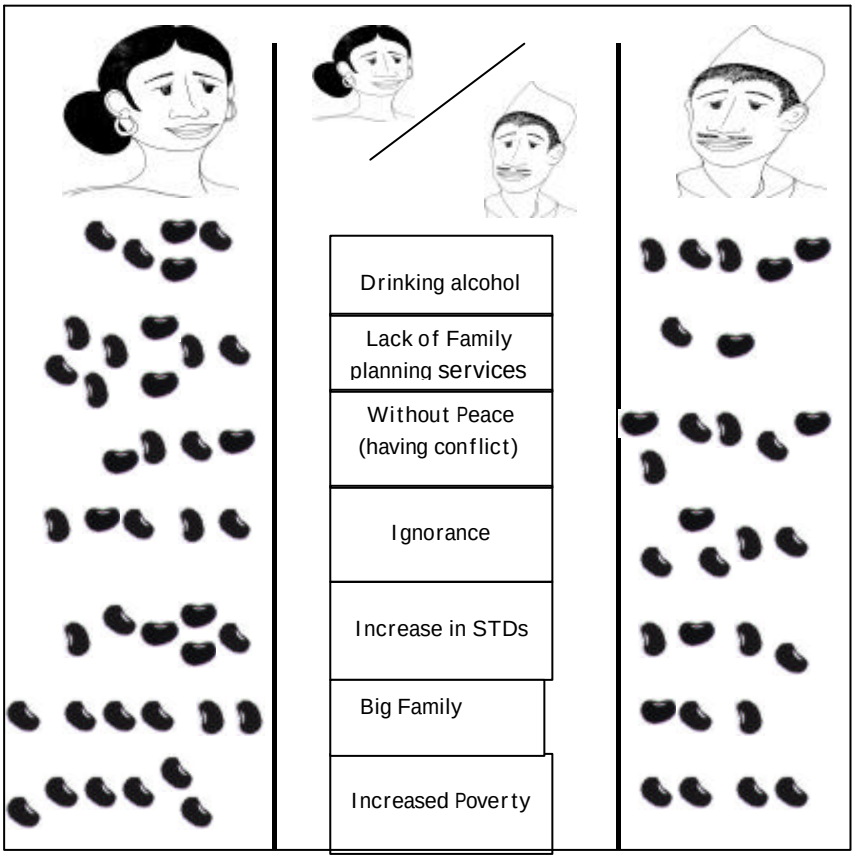

Figure 4. Example of consequence analysis: weighting the gender differences

• Conclusion

In the months following the TOT workshop, the participants implemented the work plans they had prepared during the workshop and conducted awareness raising sessions with board members, staff and at least one affiliated women's group. During these subsequent sessions, the workshop tools and exercises were used to facilitate group discussions around reproductive health and gender issues as well as to identify areas on which to focus clinic, outreach and community efforts.

- **World Neighbors programme partners in Nepal,** World Neighbors, 4127 NW 122nd Street, Oklahoma City, OL 73120-8869, USA. Tel: +1 405 752 9700; Fax: +1 405 752 9393; Email: order@wn.org **;** Website: www.wn.org

NOTES

This article was based on the publication, *Responding to Reproductive Health Needs: Participatory Approach for Analysis and Actio*n. Denise Caudill and Nicole Haberland designed the methods and facilitated the training along with Saraswati Guatam and Gopal Nakarmi.

Responding to Reproductive Health Needs is a report and methodology guide with activities designed to enable NGO staff to better understand health from a gender sensitive point of view, analyse their current reproductive health activities, use participatory learning tools and develop action plans. The guide is well illustrated and contains brief reports, descriptions of 15 training exercises, simple explanations of procedures for facilitating the trainings and specific examples of project results. (1999, 76 pages, US$10.00)

World Neighbors is a people-to people, non-profit organisation working at the forefront of worldwide efforts to eliminate hunger, disease and poverty in Asia, Africa and Latin America. Our purpose is to strengthen the capacity of marginalised communities to meet their basic needs. We affirm the determination, ingenuity and inherent dignity of all people. Working in partnership with people at the community level since 1951, World Neighbors is recognised as a leader in participatory community development.

For more information or to order a copy of Responding to *Reproductive Health Needs*, contact World Neighbors.

7

Collaborative planning to improve women's health

Carla Rull Boussen

• Introduction

Since the mid 1980s, we have been working to ensure that people are involved at each step of the development process, from programme design to evaluation. Through planning workshops, we have brought together communities, non-governmental organisations (NGOs), and government staff and officials to develop plans for improving women's health. While in almost all cases, the efforts have been considered successful and the resulting programmes indeed better than they would have been without the input of the various actors, we have been concerned that the resulting plans were not as good as they perhaps could have been. With that observation, we committed ourselves to providing planning groups with the information, background and process needed to develop sound programme plans. To ensure this, we took advantage of the combined experience and knowledge of the group, all available information plus that which could be gathered within a short period using participatory methods, as well as lessons learned elsewhere. This has led to the development of an approach we have named collaborative planning.

Elements of this process have been used successfully over the last 10 years to organise the following:

- rural water users in Central Tunisia to build and maintain community wells;
- the implementation of a national population policy through a grassroots grant fund in the Gambia;
- the development of a safe motherhood programme in Rwanda;
- the improvement of health services in rapidly growing urban neighbourhoods in Istanbul, Turkey; and,
- focusing and expansion of NGO efforts in women's health in Egypt.

This article will briefly describe the collaborative planning process using examples from our work in Beni Suef, a governorate[1] in Upper Egypt.

• Background

The Beni Suef initiative was designed to help Egyptian NGOs have the most impact possible in improving the reproductive health of Egyptian women. The first part of the strategy was to get NGOs working on priority issues in which significant impact was indeed possible. This involved identifying the most important health problems affecting women living in the governorate and specifically those women most in need. It also involved determining the things that local NGOs did well and the resources available to them. Any successful action that could be sustained would need to build on existing strengths and resources of local NGOs and a practical assessment of what NGOs could realistically be expected to do or not do. For example, even if more delivery services (birthing services) were a critical need in an area, it is unlikely that an NGO would be able to provide maternity services. It is likely, however, that an NGO could play an important advocacy role in obtaining more services for the local population, working with government to target those areas most in need or help local health officials make delivery services more acceptable to local women.

The second part of the strategy was to get NGOs working together. Ironically, one of the key strengths of NGOs, their ability to focus on specific issues and in a particular location is also often viewed as one of their key

[1] *Governorate* is an administrative unit, like a state or district.

weaknesses. Even very successful NGO efforts can have relatively small impact because of the limited geographical and programme scope. Collaborative planning encourages NGOs to combine resources and action to address area problems. Working together, NGOs can significantly expand both their programme and geographical reach. Finally, collaborative planning is designed to combine NGO action with government initiatives. By co-ordinating NGO efforts with government initiatives, the potential impact of their work can be multiplied.

Collaborative planning is a three-step process. A typical planning group would comprise local residents, local NGOs, area health staff and government authorities, who would then meet over a four to six-month period to go through the following steps with a series of workshops in the following areas.

- Preparing to Plan
- What do we know now?
- What else do we need to know in order to develop a sound programme?
- Gathering additional information
- The final workshop: analysing the information and making decisions

Key aspects of the process are discussed in the following section.

• Collecting the information needed for decision-making

During the initial workshop, the planning group reviews available studies and statistics in light of their own experiences. The team summarises what is known about the health of women in the area and the factors affecting it and then identifies what additional information is needed in order to make sound programme decisions to improve local women's health. The remaining questions are organised into a chart which shows the question next to how it will be answered. This chart forms the information collection plan for the second phase. What is collected flows directly from what the planning group has determined as essential during the first workshop The type of information collected depends on what the planning group has deemed to be the most important questions to answer, in order to develop good programme plans during the first workshop.

As collaborative planning is designed to bring about NGO action that uses all resources in the most effective way possible, information is gathered on resources as well as problems. The team considers existing resources within communities, strengths and on-going activities of NGOs working in the area, as well as the types and amounts of development funding available. Table 1 shows examples of resource information frameworks from the Beni Suef work.

A variety of information sources and collection methods

Participatory appraisal procedures are key to the collaborative planning process. During the information-gathering phase, the planning team learns more about local communities and their health needs using a range of participatory tools, such as community timelines, pile-sorting and ranking exercises, community transects, client-mapping plus other methods developed on-site. As well as adding significantly to what is known about women's health in the area, working together in the field builds respect and promotes strong ties among planning group members. Community members often take the lead at this point and are able to share their knowledge and experience.

Since participatory assessment methods generally provide only a certain type of information, the results are combined with other information sources, including health centre records, findings from traditional research studies, and national and regional statistics. In this way, the group is able to cross-check information from a variety of sources, including their own experience. This provides a broad and in-depth picture of the situation and enables the group to develop sound programme recommendations likely to work. Also, because participatory methods are carried out within the context of a programme planning process, community input and important qualitative information directly impact upon the programme outcome.

Table 1. Examples of resource information frameworks from the Beni Suef work

Programme Option 1 *Boy leaders' programme* • Local NGOs identify 3 to 4 boy leaders in each area. • Conduct problem-posing sessions with boy leaders within each district. • With boy leaders, develop and implement strategy to reach other boys in the district. • Coordinate with CEOSS (NGO)	**Programme Option 2** *Girl peer education programme* • Local NGOs organise girl groups in their areas. • Conduct problem-posing sessions with girl groups. • Support local follow-on activities. • Contact CEDPA (international NGO) to learn experiences.
Programme Option 3 *Community theatre programme* • YAPD (youth NGO) develop a series of community theatre pieces. • YAPD/BS co-ordinate with local NGOs to conduct these within communities. • Local NGOs hold follow-on discussions with community leaders. • Local NGOs identify and carry out actions recommended by local leaders	**Programme Option 4** *Parents' Groups* • Organise groups of parents that can eventually carry out joint action. • Conduct problem-posing sessions with parent groups. • Support parents' groups in follow-on action
Programme Option 5 *Sports for girls.*	

Group analysis and decision-making

An important aspect of the collaborative planning process is the emphasis on using, not just collecting, information. Workshop methods help the planning group easily consolidate, compare, and contrast information from a variety of sources while building on knowledge and experience of each group member. To facilitate group discussion and analysis, information is posted on flipcharts on the wall by topic clusters. In a corner of the room, for example, comments gathered from community men and women about delivery practices and preferences and the perspective of local TBAs (traditional birth attendants) is posted next to national statistics on maternal mortality, morbidity, the programme recommendations of a national maternal study, and an area map showing maternity facilities in the area and who is using them. Other clusters of information are posted in other parts of the room. The data is presented in a simple visual form that enables group members with little formal education as well as highly-trained managers and medical specialists to assess the situation at a glance and then, together, discuss implications for the programme. Throughout the process, the facilitator makes sure all group members have an opportunity to share their perspectives and pushes the group to compare and contrast all information. The facilitator challenges the group continually to explain and justify their decisions. In this way, programme decisions emerge from the interplay of the diverse backgrounds and experiences of planning group members supported by a rich array of programme information.

Lessons learned elsewhere

Starting from the first workshop, the group discusses strategies that have worked in other places and how the experiences can be applied to their own context. The Beni Suef group considered lessons learned in places as diverse as a community living in a landfill site on the outskirts of Cairo, rural villages from Central Africa and Indonesia, crowded urban neighbourhoods from Haiti, Bangladesh and the USA etc.. Brief summaries of relevant research studies are also shared with the group. These are introduced as evening reading with a brief discussion at the beginning of the following day.

BOX 1

PRIORITIES FOR NGO ACTION

There is much that can be done at the community level to improve the health of girls in Egypt today. Data reviewed during the collaborative planning process indicates that there is indeed a series of health problems that begin with the girl and continue as she becomes a teenager, a wife, a mother and at last, a grandmother. The data also shows that a girl's health is closely linked with other aspects of her life, such as her level of schooling, her position in the family and the future opportunities available to her which all affect her self-esteem and how she is viewed by others. By focusing attention on the health needs of a girl throughout her life cycle and by providing families and communities the necessary information and support to take appropriate action, Beni Suef NGOs can make an important contribution to improving girls' and subsequently, women's health. NGOs participating in the collaborative planning process identified this as a priority area for co-ordinated NGO action in Beni Suef.

Rather than just raising awareness, we suggest a more action-oriented approach that uses information and dialogue to encourage reflection and mobilise efforts within communities. The initiative could also be broadened to include women's health issues directly alongside those of young girls. Activities could include:

- community theatre, to approach issues affecting girls' health;
- discussion groups of young women and men to talk about their questions and concerns;
- problem-posing sessions with community men to identify ways to ensure better health for their daughters (and their sisters, wives and mothers);
- parent-teacher action groups to support school-based initiatives for girls; and,
- women's groups to provide advice and support to their daughters and to one another in reproductive health matters.

• Priorities for action

The process culminates in the identification of priorities for co-ordinated NGO action. Beni Suef NGOs identified three priorities:

- alerting communities to danger signs in pregnancy;
- getting reproductive health services to areas currently not served; and,
- raising awareness about the health of daughters.

The focus then moves to programme strategies, and we have found that an additional push for creativity and new approaches is often still needed. Following insightful analysis of the situation, groups often fall back to programme activities that they know, such as raising community awareness, providing information through health talks, etc. The continuing role of the facilitator in providing technical feedback and guidance at this point is illustrated in the summary of the selected priority action points and the options for action are used as a discussion starter in the NGOs programme discussions (see Box 1). The next step is organising collaborative action. Implementation planning is now underway in Beni Suef. One of the first tasks was to establish criteria for NGO participation in the joint programme. NGOs also outlined the desirable level of collaboration for each activity and the mechanisms to bring it about. In some cases, simply sharing information and feedback is adequate to ensure efforts are co-ordinated. In other cases, pooling resources is necessary to make the most of the collaborative partnership.

• Summary

At a minimum, the collaborative planning process results in less overlap and duplication of service; at its best, it captures the synergism possible through concerted action of NGOs on priority issues. Collaborative planning creates partnerships between and within communities, NGOs, and government, and builds commitment for action. It is effective in mobilising communities, NGOs and government for the improved well-being of women.

- **Carla Rull Boussen,** 13 Rue Taieb Mhiri, Carthage-Dermech, Tunis 2016, Tunisia. Email: H&C.Boussen@planet.tn

NOTES

The collaborative planning team in Egypt were Elizabeth Bennour, Kamel Lolah, Ahlam El Alfy, Essam Adel Allam and Tandia Samir.

8

Participatory and learning action as a tool to explore adolescent sexual and reproductive health

Mary Simasiku, Gladys Nkama and Michelle Munro

• Introduction

When CARE Zambia used participatory research techniques to explore issues around adolescent sexual and reproductive health (SRH) (Kaul Shah, Zambezi and Simasiku 1998), the findings that emerged were worrying.

- Adolescents reported early initiation of sexual relations.
- Despite this, their information about reproductive health was often incomplete and incorrect.
- Sex among young people typically involved some type of an exchange, for example, money, test answers or sweets.
- Sources of information were frequently unreliable ones.
- Young people seldom used clinic services because they found service providers to be unwelcoming.

Involving young people in the research was the first step in the design of appropriate adolescent reproductive health programmes in CARE supported Ministry of Health clinics and their catchment areas. This article discusses CARE's experiences.

• The context

Zambia has high HIV prevalence with 19.9 percent of the population over 15 years of age estimated to be HIV positive. Among 15-19 year-old girls, infection rates are five times that of boys. Sexually transmitted infections (STIs) are also widespread, although their prevalence is not well documented. By the age of 20, one-third of Zambian girls will have initiated their childbearing careers and there is considerable unwanted teenage pregnancy. Despite the fact that service providers are mandated to provide SRH information and services to young people by the Zambia Family Planning in Reproductive Health Policy, service statistics showed that few adolescents sought reproductive health information or care from clinics. CARE embarked upon a sexual and reproductive health project because of these issues.

Involving youth through participatory research

CARE chose to adopt a participatory research approach as it was felt this would provide richer baseline information from the point of view of the young people that would then be fed into the project design. Thus adolescents, their communities and service providers were involved from the outset, not only as subjects but also as researchers.

Participatory methods help participants carry out their own analysis and appraise their own situation. The emphasis is on allowing people to feel free to identify and explore their concerns. Unlike most research, there are no predetermined questions. The process is left open ended and flexible in order to follow concerns and issues brought up during the research process. CARE chose a participatory methodology because:

- we had successfully used participation in other health and livelihood projects;
- adolescent reproductive health is a sensitive issue and we felt that we would be more likely to find out the truth if we worked with adolescents on their own terms;
- there was little qualitative data on adolescent sexual and reproductive health based on their own perceptions of their sexual behaviour; and,

- involving adolescents at this level would be a starting point for youth empowerment.

We used and adapted participatory tools to work with young people. Alongside 'standard' PRA tools, such as transect walks, social and body mapping, matrix ranking and scoring and Venn diagrams, the team used focus group discussions and in-depth interviews to understand young people's perspectives. Picture stories made up and illustrated by the adolescents gave further insights. By analysing the stories together, we were able to start to understand adolescent sexual behaviour, the types of sexual relations among the boys and girls and the consequences of these relationships.

One innovation that generated rich insights was the use of a participatory sex census. During group discussions it became clear that while boys spoke about their sexual behaviour and experiences freely, girls tended to be secretive about their experiences. So a secret ballot was used to explore issues such as the age of sexual initiation. The method uses slips of paper depending on the number of questions one has to ask. One question is asked at a time and the response is written on the slip of paper. The responses are kept anonymous so that participants feel comfortable writing honest answers. The slips are destroyed in front of the group. New slips of paper are then passed round for each question. The results were analysed with the young participants and then discussed. This method allowed us to generate qualitative information that was used for comparison with the results of other analyses, which were based on perceptions.

What did we find out?

Research findings indicated that adolescents have incomplete, inaccurate and distorted information on sex and reproduction (see Box 1). They mainly depended on unreliable sources of information such as friends, grandparent, elder siblings, traditional healers, science teachers, community-based organisations and pornographic video films. Very rarely were parents and clinics mentioned as sources of information. We found differences when working with boys and girls. Boys were more open when discussing their personal experiences. Girls, on the other hand, were shy to talk about sexual matters. They always answered questions in the 'third person'. It was also difficult to have discussions with girls very early in the morning or towards lunch, because they were busy with household chores, while the boys spent several hours with us.

The average age of sexual initiation found was 10 years for girls and 12 years for boys. Reasons for indulging in early sex ranged from the need for money (especially among girls), peer pressure, curiosity, for pleasure or fun to obtaining favours such as sweets or assistance with homework. The major impact of adolescent sexual activity upon these youths was the spread of sexually transmitted infections and teenage pregnancy, 75% of which had ended up in abortions. Many young people reported the use of unsafe abortion methods. This was exacerbated by the low use of contraceptives, especially condoms and the general lack of information about services.

Clinic utilisation among adolescents was found to be very low especially for sexual and reproductive health. Only about 30% of the boys with sexually transmitted infections reported that they would seek treatment at a clinic. The proportion of infected girls seeking treatment at the clinic was even lower. Reasons identified for this low utilisation were fear of clinicians' attitudes and lack of knowledge about the services available.

• Next steps

Our participatory research led to CARE implementing adolescent sexual and reproductive health programmes in peri-urban compounds (shanty towns) of three cities, Lusaka, Ndola and Livingstone. We are continuing to work with and through adolescents and clinicians as a further step in the participatory research.

At clinic level, health workers are supported to provide youth friendly services, to form youth corners in clinics, to conduct outreach activities and to work towards improving the record keeping system.

BOX 1

QUOTES FROM YOUNG PEOPLE

'*Sometimes they only want to touch parts of our body and sometimes they also pinch us. They also ask us to have sex'* explained a group of 9-15 year old school girls. They added *'When they ask us to have sex, we have to agree.' 'Because if a girl refuses, the boy will not help her with homework and may refuse to lend her a pencil when she wants one'.*

'*The Kasai or the Zairien sex workers have a more or less fixed rate for the services they provide. For the night they charge K4000 ($1.6), for half the day they charge K1,500 ($0.6) and for one round of sex you have to pay K1,000 ($0.4)'* - boys in Chawama compound

'*Rape is when an older man has sex with a much smaller girl and in the process tears her vagina .....the vagina tears because the man's penis is large'* - Definition of rape by a group of 9-15 year old school girls in Chawama

'What have you been doing so far?' Group of 13-17 year old boys discussing their sexual experiences when one 13 year old boy mentioned that he had not had sex up to this point.
'*Having sex with a condom on is like chewing a sweet with its wrapper on' On why there is low condom use among adolescents*

'If a boy has an STI, everyone comes to know about it. However, if a girl has an STI, it is not possible to tell for a long time. Boys have to be very careful otherwise the girls will give us all the diseases. I make sure she is clean every time I have sex with a girl.....before having sex with a girl, I put some cigarette ash in her vagina...if she has a disease it will hurt and she will scream'. A group of 13-17 year old boys in Chawama.

At the community level, the project has facilitated and supported groups of trained peer counsellors in community based adolescent health education activities. When the results of the research were disseminated to the community, young people suggested that one of the activities they would want to be included in this project was health education. They were then encouraged to form discussion groups, each of which had 10-15 members. They determined their own criteria for selecting group members. The same discussion groups were used to brainstorm the qualities of a good peer counsellor. Some of the qualities listed included being respected, responsible, accessible, of the same age group and not having many girl/boyfriends. Then the groups were asked to select one or two people from their group to be their leader and these were trained as peer counsellors. Peer counsellors also work in the youth friendly corners and act as a link between service providers and youths.

Things we might have done differently

We have learnt that it would have been good to develop strategies that help peer counsellors become economically active in order to reduce attrition rates. It would have also been good to focus on a small geographical area and stagger the training sessions for adequate follow up.

• Conclusion

Adolescent sexual behaviour has serious implications, demanding an extensive range of interventions. This requires adolescents themselves, the community, health workers and facilitating agencies to work continuously together in partnership. CARE has taken steps to address this in partnership with the Ministry of Health.

• **Mary Simasiku, Gladys Nkama and Michelle Munro,** CARE Zambia, P.O. Box 36238, Plot 3020, Musi-O-Tunya Road, Woodlands Shopping Centre, Lusaka, Zambia. Email: care@zamnet.zm

REFERENCES

Kaul Shah M, Zambezi R, Simasiku M (1999) Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents. *CARE International in Zambia, FOCUS on Young Adults*.

9

Lessons from 'Auntie Stella': using PRA to promote reproductive health education in Zimbabwe's secondary schools

Barbara Kaim and Ratidzai Ndlovu

• Introduction

In early 1997 the Adolescent Reproductive Health Education Project (ARHEP), a project of a Zimbabwean non-profit organisation called the Training and Research Support Centre (TARSC), set out to find out what information, perceptions and concerns adolescents have about their reproductive health and their sources of information and support. Drawing on our collective experiences and understanding of participatory approaches, we aimed to prioritise the views of the adolescents themselves. We focused our research on four rural schools which, although a small sample of the 1500 secondary schools in the country, allowed a more in-depth review of the adolescents' views of their reproductive health. In the beginning, our research was open-ended, meaning that if we were to be true to the opinions of the youth in the schools, we could not predict the outcome of our findings nor what would follow.

The results of this initial research continue to have an impact, not only on the original pilot schools (expanded to a total of 12 schools to date), but also on the policy and strategies of the Ministry of Education, the Ministry of Health, a number of NGOs participating in our Reference Group, as well as having a ripple effect on groups working with out-of-school youth.

Much of this success can be attributed to our continued emphasis of listening to the views of the adolescents themselves, respecting their opinions, and drawing on their own experiences to analyse and act on their problems and priorities. Our early research showed unequivocally that, while teenagers are subject to strong social, economic and peer pressure in many areas, they lack sources of open, reliable support and information. For example, girls from one remote rural school show how community and government institutions, and even the Guidance and Counselling teachers who are mandated to provide AIDS education for 40 minutes per week, are not prominent (see Figure 1). Instead, adolescents repeatedly said that they were either getting information from family members (but not parents, who are conspicuously absent in the sexual education of their children), peers (although much of the information shared is superficial and inaccurate) and the media.

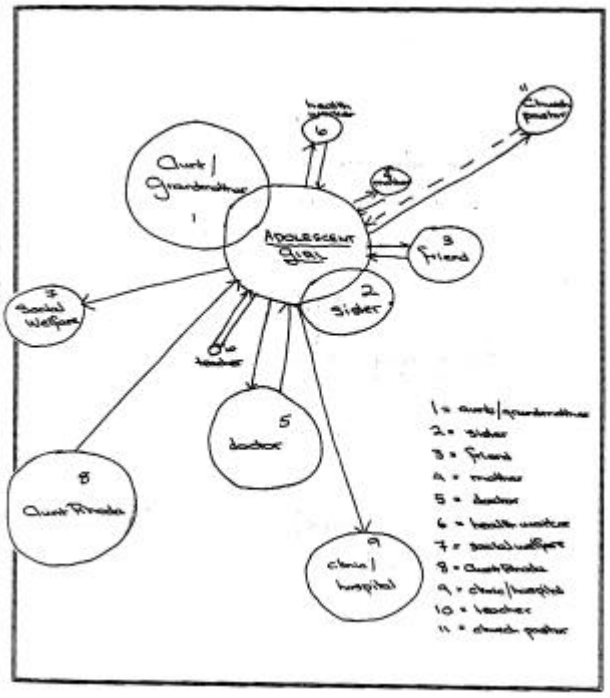

Figure 1. Sources of information and support – Chemhondoro girls

In exploring this last point further, teenage groups acknowledged that an alternative source of information came from magazine helpline letters, such as those written to 'Aunt Rhoda' and published monthly in a widely circulated magazine in Zimbabwe. None of the youth we worked with had written in to any of the magazine helplines, but they found the question and answer format and style of writing accessible and informative.

The creation of 'Auntie Stella'

The findings from this early participatory research led to the development of a reproductive health education pack called 'Auntie Stella', based on the stories, experiences and expressed needs of the adolescents themselves and using the question and answer format of helpline letters. It is a classroom-based activity pack for secondary school pupils aged 14 and above and has the following aims:

- to stimulate discussion among adolescents on key issues related to their reproductive health and to give reliable information about these issues;
- to create an activity and atmosphere where pupils are able to talk to each other freely and without inhibition;
- to fill a proven 'information gap' by providing advice in a non-authoritarian framework;
- to encourage pupils to express their own problems and questions, and to steer them towards suitable sources of information and help where relevant; and,
- to provide support and extra resources for already existing schools programmes developed by the Ministry of Education, Sport and Culture.

'Auntie Stella' consists of 33 questions and answer cards, the questions supposedly written by adolescents seeking information and/or advice on a variety of topics. The answer cards give Auntie Stella's reply. The topics covered include normal reproductive development, social and economic pressures to have sex, gender roles, forced sex, communication in relationships and with parents, depression, wanted and unwanted pregnancy, infertility, cervical cancer, HIV/AIDS and Sexually Transmitted Diseases (STDs).

Cards are discussed in small groups, which are usually of single-sex, with minimal intervention by the teacher. The cards can be used for approximately eight to ten 40-minute class periods. In the basic lessons, groups discuss the problem raised on the question cards, guided by the 'Talking Points' which follow each letter. Then they take the matching answer card and read and comment on what it says, using the 'Action Points' to focus on future action. In later lessons, pupils work, first in pairs to write answers to the letters, then write and discuss their own letters to 'Auntie Stella' before finally discussing specific letters, if they so choose, with pupils of the opposite sex.

The 'Auntie Stella' methodology is based on findings that adolescents are most at ease when talking to peers of the same sex but feel inhibited in full-class discussion and in discussions with pupils of the opposite sex, especially in the presence of the teacher. The pack includes a 'Teacher's Guide' which stresses that the teacher is a facilitator rather than a controller, and insists that pupils' discussions and writing are private.

Measuring the impact of 'Auntie Stella'

Since the production of 'Auntie Stella', TARSC and the Ministry of Education have been working closely in field, testing the pack in a number of schools in one region of Zimbabwe. One objective, in addition to exploring what local capacity is needed in order to implement a participatory reproductive health programme in the schools and how the experiences in the pilot schools can be made effective at national level, was to determine whether or not students gained new knowledge from 'Auntie Stella' and whether they put this knowledge into practice. From a methodological viewpoint, we were interested in designing an approach which gave the students in our pilot schools the opportunity to define their own indicators of change.

This was an ambitious task and, even at the outset, the ARHEP team was aware of its potential difficulties. We went about doing

this through a series of steps: in the early weeks of the students' exposure to 'Auntie Stella'. First, we asked them to describe which reproductive health behaviours they and their peers engage in, factors which influence their behaviour, and how they assess these behaviours (see Tables 1 and 2). We triangulated this information by interviewing teachers in the school. Later on in the programme, we returned to the schools and focused on those behaviours that the students' themselves had defined as 'bad'. For example, having sex, having 'sugar daddies' or 'sugar mommies', abortion (girls), smoking (boys) or *chiramu* (when an older man touches the girl's private parts). All of these activities were defined by the students as risky because they led to irresponsible behaviour with sometimes fatal outcomes.

We used the image of a river with one side representing the prevalence of that bad behaviour and the other where that behaviour no longer exists in their community. Then we asked the students what stepping stones (pieces of paper with specific actions written on them) they needed to cross from one side to the other. Crossing the river symbolised a change in attitude or behaviour; the stones were the students' indicators of change.

An initial interpretation of the stepping stones (indicators of change) defined by the students was interesting in itself. Students tended to focus on ways of *avoiding* risky behaviour. For boys who no longer wanted to pressurise girls into having sex, this meant avoiding having too many friends, not watching sexual movies or not walking in the bush with their girlfriends. For girls not to fall pregnant, they suggested they avoid nightclubs and having sex before marriage. Rather than being proactive and making suggestions about what they *can* do to change unwanted behaviour, they found it easier to identify what they should *not* do. They only peripherally mentioned the role that community institutions (such as family, friends, clinic, church etc.) could play in supporting their efforts to change a certain behaviour. Their strategies for trying to create a more positive reproductive health environment for themselves and their peers was often broad-sweeping (e.g. resist peer pressure), individualistic and lacking the necessary detail to be measurable.

Table 1. Behaviour influence matrix table for boys

	Peers	Biological instincts	Entertain-ment	Family	Culture	Economic pressure	Religion
Sex	8	9	7	3	2	3	2
Smoking	8	1	4	3	3	4	1
Alcohol	8	2	5	4	5	4	2
Masturbate	4	8	3	2	1	2	0
Girlfriends	9	8	8	4	3	1	4
TOTALS	**33**	**28**	**27**	**16**	**14**	**14**	**9**
RANK	**1**	**2**	**3**	**4**	**5**	**5**	**6**

Table 2. Behaviour influence matrix for girls

	Peers	Economic pressure	Entertain-ment	Family	Culture	Nature	Religion
Sex	8	7	8	2	4	8	2
Abortion	7	7	0	4	2	0	1
Marriage	6	7	2	7	5	3	7
Boyfriends	8	8	7	6	4	6	4
Masterbate	10	0	3	5	0	5	0
'Sugar dad'	9	7	0	5	4	2	3
Alcohol	6	3	7	2	5	0	1
TOTAL	**54**	**39**	**37**	**31**	**24**	**24**	**18**
RANK	**1**	**2**	**3**	**4**	**5**	**5**	**6**

- We returned to the schools once again a few months later to explore how students (and teachers) viewed the impact of 'Auntie Stella'. To our surprise, despite the students' prior over-generalised statements of how they could change their behaviours, they were very precise on the outcomes of their increased knowledge as a result of exposure to the 'Auntie Stella' pack. They cited evidence of:
- an increase in communication with parents, community members (e.g. some students had asked community elders about the traditional roots of *chiramu*) and with their peers;
- greater confidence and ability to make informed decisions and take initiative (e.g. to report seemingly harmless overtures by their in-laws so that they do not appear to be encouraging or inviting abusive behaviour); and,
- their increased ability to advise their peers on a range of reproductive health issues (e.g. telling their friends that they have rights over their own bodies; girls talking to their younger sisters about their first menstrual experience and telling them how to manage period pains).

While these focus group discussions also elicited a range of negative attitudes (where some boys still maintained that a girl means 'yes' when she says no'), there was a general feeling from boys, girls and teachers that the 'Auntie Stella' pack has had a positive impact on reproductive health behaviour.

• Lessons learnt from 'Auntie Stella' and the use of PRA

- Adolescents react positively to PRA. There was remarkable enthusiasm, participation and a general interest in the unfolding process. From the very beginning, boys were eager to talk. The girls were more reticent to start with, but opened up once they realised that this was a rare opportunity to share opinions and experiences. Clearly there is a need for more open and accessible channels of information and communication for adolescents.

- The concept of 'Auntie Stella', its format, the content of the letters and its methodology, arose directly out of the PRA research with the students and teachers in the original four schools. Initially, the ARHEP team was concerned that the pilot may be too small to represent the views of other teenagers in other schools. However, the first four schools and subsequent eight schools represented a good cross-section of the situations in which school-going adolescents find themselves. In all twelve schools, both students and teachers acknowledged that the letters reflected real problems faced by the students. This process emphasises the importance of designing educational materials only after serious dialogue with the end-users themselves.

- The project has shown that indicators of change do not have to be imposed from the outside but can evolve as part of the research design. This more qualitative approach to evaluating behaviour change does not preclude more quantitative measurements; it does, however, give voice to the participants themselves, who are ultimately the key players in the process.

- ARHEP's work reached a new phase with the signing of an agreement between TARSC and the Ministry of Education, Sport and Culture to work together in finding ways in which the Ministry can strengthen reproductive health education in the schools. Potentially, this relationship may have far-reaching consequences, including an impact on Ministry policy and/or distribution of the 'Auntie Stella' pack to a larger number of secondary schools in the country.

- The role of the ARHEP Reference Group, consisting of representatives from government, non-governmental and community groups involved in health, education and gender issues, deepened the work of this programme. Their input was invaluable during each phase of the project, in giving guidance and in exploring ways in which existing youth-oriented organisations can use ARHEP's findings.

- The role of the teacher, as defined in the 'Auntie Stella' pack, deepened the debate on how to implement a successful reproductive health education programme in the schools.

- One of the limitations of this research, was that the ARHEP team was confined to working within the school timetable. This often meant that not enough time was spent with the students in each school.

- Financial constraints limited the number of researchers who went out into the field. There was need for a larger multi-disciplinary team, including health personnel, so that at least two people could work with one group.

- There was a tendency for adolescents to exaggerate their stories. They were excessively critical of the adult community, especially their parents.

Where to from here?

Findings from ARHEP's field testing of 'Auntie Stella', reinforced by a positive external evaluation of the programme, supports the strategy of exploring ways in which 'Auntie Stella' can be distributed to schools in other regions in Zimbabwe. This will involve discussions with the Ministry of Education and other relevant players and, eventually, the devolution of responsibilities for the future of the pack onto larger national institutions.

At the same time, ARHEP plans to continue working with students from the initial pilot schools. Our intention is to involve them in a structured dialogue with health providers in their communities to explore ways in which the providers (clinics, village health workers, community-based distributors, traditional healers etc.) can better support adolescent reproductive health needs. The dialogue will follow specific areas of interaction between adolescents and services, for example, fertility regulation, prevention and management of STDs, etc., and will examine how information, service environments, type of service, professional/client interaction and other aspects can be improved to enhance access, use and effectiveness of services for adolescents.

• Conclusion

The use of PRA in this project has shown that learning is not just about adults teaching adolescents. Of great value is recognising that we, the adults, have a lot to gain from listening to adolescents as part of the process of sharing information with and giving support to young people. There is evidence that adolescents are sexually active and they need appropriate educational materials which meet their specific needs. The 'Auntie Stella' education pack has gone a long way in exploring strategies on how to meet some of these needs. It is hoped that, in the long term, the ARHEP programme will have some impact on education and health policies in government and non-governmental institutions, on methods of working with young people and, of course, on the behaviour patterns of the youth themselves.

- **Barbara Kaim, Co-ordinator,** Adolescent Reproductive Health Education Project (ARHEP), Training and Research Support Centre, 47 Van Praagh Ave, Harare, Zimbabwe. Tel: +263 4 708835 or 573059; Fax: +263 4 737220; Email: jbrakarsh@mango.zw and **Ratidzai Ndlovu,** Adolescent Reproductive Health Education Officer, Ministry of Education, Sport and Culture, P.O. Box MP 133, Harare, Zimbabwe. Tel: +263 4 333812

NOTES

The ARHEP reference group referred to in the text consists of representatives from government and civic organisations working in the fields health, education and gender. The group meets every three months to give input into the design and implementation of the programme and to encourage a closer interaction between the various programmes.

Inspiration for the activity where the image of a river was used, with one side representing prevalence of 'bad' behaviour and the other where that behaviour no longer existed, was inspired, in part, from 'Stepping Stones', the training package of HIV/AIDS by Alice Welbourn.

10

More talk, less sex: AIDS prevention through schools

Noerine Kaleeba, Joyce Kadowe, Daniel Kalinaki and Glen Williams

• Background

"Why is it that someone can at times have an erection even when he doesn't want it?"

"Is someone likely to get AIDS by kissing an infected person?"

"Can HIV be contracted after only one single sexual intercourse with an infected person?"

These are just a few of the frank questions about sex and HIV/AIDS which primary school pupils in Soroti District, Uganda are putting into their 'health letter boxes'. The health letter boxes are part of an innovative School Health and AIDS Prevention Programme, which has helped to dramatically reduce sexual activity among primary school pupils. The letters are read out to the children during morning assemblies and answered on the spot by specially trained teachers. As in many other countries, sex in Uganda has long been regarded as a taboo subject, which causes feelings of embarrassment or even shame when discussed in public. Yet this has not prevented large numbers of young Ugandans from becoming sexually active. A national survey in 1995 found that on average, girls became sexually active at the age of 16, and that 30% of girls had engaged in sexual intercourse by the age of 15[1]. In some parts of Uganda, up to 62% of boys and 38% of girls were involved in unprotected sex before completing primary school (Bagarukayo et al. 1993). This pattern of sexual activity was clearly exposing many young people in Uganda to a high risk of unplanned pregnancy, Sexually Transmitted Diseases (STDs) and HIV/AIDS.

In the early 1990s, the District of Soroti, in eastern Uganda, was struggling to emerge from several years of civil war. Many schools had been looted and damaged during fighting between dissidents and government forces and large numbers of children were attending classes in the open air. Although about 90% of children were reported to be starting primary school, (which has covers the range of 6–20 years of age) only 40-50% were actually completing the full seven-year course. Many children were in their late teens by the time they left primary school.

Health education, including AIDS prevention, was already part of the primary school curriculum in Uganda at this time. However, teachers generally lacked the training and the skills needed to talk explicitly about human reproduction and sexual health, and to encourage their pupils to discuss intimate sexual matters.

• Programme strategy

In 1993 the African Medical and Research Foundation (AMREF), together with the Soroti District Administration, started a School Health and AIDS Prevention Project in 95 primary schools, with an enrolment of about 120,000 children, in two rural counties and Soroti town. A baseline survey of primary school pupils aged 13-14 in the project area in 1994 found that 42.9% were sexually active. Boys were more likely than girls to be

[1] Statistics Department, *Demographic and Health Survey*, Ministry of Finance and Economic Planning, Entebbe, 1995.

sexually experienced: 61.2% of boys claimed to have had sex, compared with 23.6% of girls (Shuey et al., 1999).

The project aimed to encourage safer sexual behaviour, particularly abstinence, amongst primary school pupils, through a three-pronged operational strategy:

- improved access to information about healthy sexual behaviour and decision-making;
- improved adolescent-to-adolescent interaction regarding information and decision-making relating to AIDS, sexuality and health; and,
- improved quality of the existing district education system in the implementation of the school health curriculum and in counselling/advice-giving to school pupils.

Beyond embarrassment

The new approach was not without risks. Objections were to be expected from traditionally minded parents, as well as cultural and religious leaders. The project made meticulous preparations, therefore, to minimise the likelihood of misunderstandings, social tensions and outright opposition. A District level Steering Committee was appointed to oversee the activities of the project. This consisted of officials from the Departments of Education and Health, local government personnel, religious leaders, representatives of parents, youth and women's affairs, and staff from AMREF-Uganda. Headmasters and local leaders (politicians, government officials, religious and local opinion leaders) were sensitised about the aims of the project through a series of one-day workshops. The project also organised meetings to discuss health and sex education with local parents, community leaders and teachers at each school and in each administrative zone. Teachers were also thoroughly prepared: Senior Women Teachers (SWTs), Senior Men Teachers (SMTs)[2] and Science teachers attended four-day health education training courses to improve their knowledge and health education skills. Looking towards the longer-term future, the project helped local teacher training colleges to introduce school health, AIDS prevention and Child-to-Child health learning techniques into their training courses.

When the project entered primary schools, teachers initially encountered some reluctance on the part of pupils to discuss sexual matters and AIDS in a frank and open manner in the classroom. However, these inhibitions were soon overcome, and pupils responded positively to the more open approach (i.e. being frank and specific) to teaching about human reproduction, sexual health and AIDS.

Perhaps even more influential were the weekly 'guidance and counselling' sessions run by the SWTs and SMTs for pupils in years five, six and seven (aged between 11-14, but pupils can often be older). These sessions, often held in small groups sitting under a tree, gave pupils the chance to interact with one another informally, with guidance and support from teachers whenever necessary. They took the form of teacher facilitated group discussions, with the use of drawings and posters to support them. Particularly useful to the guidance and counselling sessions were copies of the newspapers *Young Talk* and *Straight Talk* supplied free to schools by the Straight Talk Foundation[3]. These provided accurate, factual information about sex, human reproduction and HIV/AIDS, and also stimulated discussions amongst pupils, and between pupils and teachers. Many pupils also wrote to one or other of these

[2] Senior Women and Men Teachers are experienced teachers designated by schools to give guidance and counselling to pupils, alongside their normal teaching duties.

[3] The Straight Talk Foundation is an organisation whose aims are: to increase understanding of adolescence, sexuality and reproductive health; and to promote safer sex, life skills and child/adolescent rights. It publishes two monthly newspapers – Young Talk and Straight Talk, which reach over 1 million young adolescents and youth, mainly through primary and secondary schools.

newspapers to seek advice or express their opinions.

Pupils began using 'health letter boxes' at school to ask questions about HIV/AIDS, STDs and other intimate matters related to sexual and reproductive health. In addition, pupils went to teachers for individual counselling, advice or practical help. *"Girls come to me,"* says Christine Oluka, Deputy Head of Soroti Demonstration School, *"for advice about their relationships with their boyfriends, or to complain about a boy who is pestering them. They also ask about their periods. Sometimes they get their period at school but they haven't brought a sanitary towel, so we can help them deal with that."*

In every school involved in the project, groups of pupils also started extra-curricula school health clubs, whose members came together to share knowledge and experiences, and to support one another in following a healthy lifestyle. They also composed songs, staged skits and plays, and wrote poems and essays about HIV/AIDS, pregnancy and other health-related issues. The condom issue had to be handled very carefully, since many parents feared that teaching young people about condoms would encourage them to become sexually active. Most teachers confined themselves, therefore, to providing information about the condom, without showing samples or demonstrating how it should be used. Some teachers, however, brought condoms to school and demonstrated, albeit discreetly, their use to senior pupils, especially to those who are already sexually active[4].

Increase in abstinence

In 1996, after the project had been fully operational for two years, a follow-up survey was made of the sexual behaviour of a sample of pupils in year seven of primary school in the project area. An identical survey was also carried out in a 'control' group of schools in a neighbouring county, where the project was not operating. The survey found that, in the schools involved in the project, the percentage of pupils claiming to be sexually active had fallen dramatically: from 42.9% to 11.1%. Boys were still more likely than girls to be sexually active: 15.8% compared with 6.4%. By contrast, no significant changes in sexual behaviour were recorded among pupils in the 'control' group of schools (Shuey et al., 1999).

The survey also explored the reasons for this 74% decline in reported sexual activity among young people. It concluded that the main reason was greater social interaction between pupils and teachers, and among pupils themselves. This high degree of social interaction was not accidental, but was carefully fostered by the project. It was effectively reinforced by the thrice-yearly visits paid to schools by officials from the District Education Service to monitor activities and provide supportive supervision to teachers.

The channels of communication that have been opened up between the project and local families and communities have also contributed to the success of the project. Community leaders and parents were sensitised about the aims and activities of the project, and also offered the opportunity to express their views at local meetings. These efforts have helped local parents and community leaders understand and accept the aims and strategies of the project. While some parents have complained that the project has led to their children experimenting with condoms, most would probably agree with Salome Abuko, a small kiosk owner and mother of two primary school children in Soroti town, who says:

"*It's good that the children are being taught about AIDS and sex at school. The teachers aren't spoiling them but are*

[4] AMREF also sells condoms and contraceptive pills to the general public. However, this project is separate from the School Health and AIDS Prevention Project.

helping to save their lives. In fact they are helping us to do our jobs of teaching our children".

- **Feedback from project participants**

The following section provides some feedback from a selection of the project's participants, both students and teachers alike, in which they share some benefits, outcomes and learnings that have been a direct result of the project thus far.

Jesca Harriet Acao: class 7 pupil

Fourteen year-old Jesca is in class 7 at Katine Tiriri Primary School, about 20 kilometres north of Soroti.

"The greatest worry in my life is AIDS. It has killed four of my sisters and brothers. My surviving sisters at home tell me how I could get AIDS and they advise me to behave myself so that I can stay safe. We talk about AIDS in our free time here at school, and we also read the Young Talk newspaper which comes to the school. I also borrow Straight Talk from the teachers. I also listen to 'Capital Doctor' on Capital Radio on Tuesdays, and I have learned a lot about AIDS from that. We have learned about AIDS in class - how we can get it, prevention, taking care of yourself, and teaching other people back home in the village so they do not get it also.

"My parents feel happy that I am learning about AIDS and sex at school, because whatever they teach us here I pass on to them. They tell me I will have a better life in future because of what we are learning at school.

Joseph Julius Omio: science teacher

Joseph is a Science teacher at Katine Tirere Primary School. He was trained by the AMREF School Health and AIDS Prevention Project:

"As a teacher, I am now much more open with my pupils. I don't hide any facts when I am teaching about sex or AIDS in the classroom. In the past, I could feel uneasy when talking about such things. But now, even if my own child is in the class, I talk quite openly. The children sometimes have problems being open. At first they are shy and afraid to use the language to describe sexual matters. I just encourage them not to be afraid and to speak out. We also talk about AIDS at school functions, like Parents' Day and Open Day, where the pupils sing songs depicting AIDS and other social problems.

"Not everyone agrees with what we are doing. Some parents bounce the problem back to us, and say we are trying to teach their children irrelevant things, and causing them to be interested in sex at too early an age. But the Project recently ran a peer group seminar on AIDS and sexual issues for school pupils, and afterwards some of the pupils went and explained it all to their parents. I also talk to people in my community about AIDS. The death rate from AIDS seems to be decreasing, but the problem is that the people at the grassroots, who don't have radio or television, still lack information. But we shouldn't try to hide anything about AIDS. The problem is already with us so we cannot hide from it".

Grace Ebunyo: senior woman teacher

As the Senior Woman Teacher at Soroti Demonstration Primary School, Grace is responsible for the weekly guidance and counselling sessions for pupils in the top three classes of the school. She is 39 years old, married, with five children. Her life has been deeply marked by the HIV epidemic.

"AIDS has affected me a lot. In 1995 I lost my brother, who was teaching in Teso College - he had just finished his university degree. I also lost my other brother just after his training, and my

sister died when she was in her last year in teacher training college. I spent a lot of money helping my brothers and sister get a good education, but they all died so young! I'm really worried about my own children. Whenever I lose a close relative to AIDS, I take them there to see, and I even tell them the cause of death, but still I'm worried for their sake. As a teacher, I'm worried about my pupils. Today's children learn many bad things from TV and from one another".

Grace is strongly in favour of teaching about sex, human reproduction and AIDS in primary schools:

"AIDS is covered in the school curriculum, but only from Primary 5 to 7. But with UPE[5], we are now getting big boys and girls, even 15 year-olds, in Primary 1. So the curriculum should cover AIDS right from P1.

"We try to emphasise abstinence from sex as the best method of AIDS prevention, but children cannot easily avoid temptation. We have to tell children about condoms. I even show condoms to the big ones. My brother is a doctor and he has condoms in his clinic, so I can easily get them. The parents are generally very positive about the teaching of AIDS prevention in school. Many have lost their children to AIDS, so they support of what the school is trying to do.

"People in the community are much better informed about AIDS, and they are much more supportive towards people with AIDS. In the past they were afraid to touch the sick, or even to carry the body of someone who had died of AIDS to be buried. But now they know that touching someone with AIDS is not risky, so they nurse and care for the sick. And they no longer waste time analysing how someone got AIDS, which was the case in the past.
"There are some school children who share their knowledge of HIV and AIDS with their parents. I have a friend who divorced her husband 16 years back. They were planning to reconcile but her daughter, who was in Primary 6 at the time, said 'Mum, you've been away from each other for such a long time. We are not sure whether father is free from HIV/AIDS.' My friend thought seriously about what her daughter said, and in the end she declined his proposal."

Caroline Imalingat: class 7 pupil

Fifteen year-old Caroline is in class 7, her final year at Soroti Demonstration Primary School. When her teacher first started talking about sex in class, she was uncomfortable:

"I used to feel so embarrassed when the teacher was talking about sexual matters in class. I felt that such things were not supposed to be talked about in class like that. Now I don't feel embarrassed at all, because I know that such things are important and should be discussed. But some of my fellow pupils still say it's bad to discuss such things openly. I also discuss sexual matters with the Senior Woman Teacher, and with my mother, and they advise me about what to do. I think sex is very dangerous because you can get diseases which cannot be treated. It can also cause you to get married early because you become pregnant. Some parents can even chase you from home. Sex is only good when you have finished your studies and got a job and want to have children.

"I have learned about AIDS here at school, and through reading. I read Young Talk and Straight Talk at school. My friends and I, we talk about AIDS during lessons and in our free time. We have agreed to stay safe so that we do not get infected, because AIDS cannot be cured. I tell my parents what I am learning about AIDS at school. They are happy about it. They say that the teachers are helping them.
"I have good friends who are boys. I think it is possible to be a close friend with a

[5] Universal Primary Education – a government programme which began in 1998 and which aims to enable each family to have four children educated to complete primary school.

boy without playing sex. I do not have a boyfriend and have never had one. A boy can make you neglect your studies because you are thinking about him all the time".

• Expansion and sustainability

In late 1998 the project expanded to cover all 213 primary schools in Soroti District and 154 schools in the neighbouring District of Katakwi - a total of 367 schools with a total enrolment of 192,000 children.

The project employs only one full-time health educator, who is scheduled to leave the project in March 2000. The prospects for the longer-term sustainability of the benefits of the project, however, are good. Firstly, the project is based on the existing health education curriculum. It is implemented on a day-to-day basis by local teachers and officials from the Soroti District Education Department, and pays no allowances to staff outside of normal government policy (i.e. for travel expenses and to cover the costs of attendance at workshops etc.).

Moreover, the social interaction approach adopted by the project has been incorporated into the curriculum of the two teacher training colleges, which supply most new teachers for the two local Districts covered by the project. There is every prospect, therefore, that the new approach will become institutionalised, and that future generations of primary school pupils will also be equipped with the knowledge and skills they need to postpone sexual activity until they are physically, socially and emotionally mature

• **Noerine Kaleeba,** UNAIDS, 21 via Appia, 1211 Geneva, Switzerland. Email: kaleeban@unaids.org, **Joyce Kadowe,** Uganda AIDS Commission, P.O. Box 10779, Kampala, Uganda. Email: namulondo@yahoo.com**, Daniel Kalinaki,** Department of Mass Communication**,** Makerere University, Kampala, Uganda. Email: kalinakid@yahoo.com, **and Glen Williams,** Strategies for Hope, 93 Divinity Road, Oxford, OX4 1LN, UK. Email: stratshope@aol.com

REFERENCES

Shuey, D.A., Babishangire, B.B., Omiat, S., Bagarukayo, H. Increased sexual abstinence among in-school adolescents as a result of school health education in Soroti district, Uganda, *Health Education Research,* Oxford University Press, Vol. 14 (3), 1999, pages 411-419.

Bagarukayo, H., Shuey, D., Johnson, K., and Babishangire, B., An operational study relating to sexuality and AIDS prevention among primary school students in Kabale district of Uganda. Poster presentation at VIIIth International Conference on AIDS in Africa, Marrakesh, 1993.

NOTES

This article is an abridged version of a chapter from book no 15 in the Strategies for Hope series entitled, *'Open Secret: Facing up to HIV and AIDS in Uganda'*. ActionAid, London 2000.

It is available from TALC, P.O. Box 49, St. Albans, Herts, AL1 5TX, U.K. Email: talcuk@btinternet.com

For further information on the Straight Talk Foundation, please contact Kathy Watson or Ann Akia at Straight Talk Foundation, PO Box 22366, Kampala, Uganda. Email: strtalk@swiftuganda.com

To find out more about materials in the Strategies for Hope Series, please visit our website,: www.stratshope.org

11

Experiences of using a participatory approach in Cambodia: Exposing the needs of sex and good women

Julie Forder

• Introduction

Over the last eighteen months, CARE International in Cambodia, the Cambodian Health Education Development, Reproductive Health Association of Cambodia and Women Development Association have been using participatory tools for sexual health assessment with young garment workers[1]. With additional funding and technical support from FOCUS on Young Adults, the project team adapted and applied participatory methods and tools used by CARE Zambia in their work on adolescent sexual health (Kaul Shah et al. 1999). The process, which is still continuing, has enabled project staff, in conjunction with factory management and local communities, to gain more in depth knowledge with the target population about thoughts and practices regarding sexual health. It has also helped strengthen their participatory facilitation skills, along with many other transferable skills, while undertaking participatory research design, implementation, report writing, presentation and action planning with factory workers and managers. This article reflects on some of the lessons that we have learned through this experience.

[1] Factory workers committed their free time, owners and managers gave their approval to their involvement in the process.

Background

The sexual health needs assessment aimed to identify the sexual health needs of young people undertaking garment work. It was designed so as to learn with these young people about a number of aspects of their lives. These included their general concerns, their knowledge of anatomy and physiology of men and women and their relationships and sexual practices. 77 young people aged 15-23 were involved in the research, of which 75% were female, broadly reflecting the balance of the workforce in the garment factories of Phnom Penh, the Cambodian capital.

• Opening doors

The project arose out of a joint Asia initiative of the United Nations Population Fund and the European Commission. Consultation meetings within Cambodia between the government and NGO staff identified young people as a group that had many unmet sexual health needs. From CARE's previous experience of working with employees of three garment factories, a need for sexual health promotion was identified. Therefore CARE sought to continue opening more factory doors and decided to expand and adapt their experiences, not only targeting factory workers, but also factory management and health staff in an attempt to institutionalise improved factory health services.

Authorisation for this project's work was sought from a number of relevant ministries.

Access to the factories was attempted through the Garment Manufacturers Association of Cambodia (GMAC) and eventually gained through door to door visits. Forty-eight factories were visited in Phnom Penh. Thirty-two agreed to be interviewed. All expressed interest and reported that a project such as this was important, yet whilst our project was seen as 'a good idea' and requests were made by many for medicine, medical personnel and for treatment of Sexually Transmitted Infections (STIs) and gynaecological problems, it was not perceived as needed. Seven out of those factories who expressed a strong interest were selected as project sites. The selection was based upon interest and co-operation, having more than 500 employees and a greater proportion of workers who were female and predominately single.

The seven factories selected originally had, for one reason or another, 'closed their doors' to the project. Some had gone out of business, others had simply 'changed their minds' and thus, none of the original seven were included in the participatory research. A further seven had to be contacted and access re-negotiated. Out of the seven factories selected as project sites, all managers and a total of 1,200 young workers were interviewed. From these seven, three were selected for participatory research. This was based on timing, funds, but most significantly, co-operation and agreement from the factory management. The findings of the research will be channelled into upgrading clinical skills and services in five of the seven factories – the ones which after one year still wanted help from CARE.

Once the factory management had conveyed the discussions about the project to their relevant owners, permission was received to work with CARE. The researchers and management conferred and sought agreement for the days and times when access would cause least disruption to the factory schedule. Factory health staff, a staff representative or a section supervisor were approached through the manager and asked for help in selecting groups of women and men between 15 and 24 years old. The young workers were then eventually approached directly and told about the research. The final selection was controlled by the young workers who self-selected themselves with approval from the supervisor or head of section. The approval was usually dependent on the work commitments and orders that had to be fulfilled. The participatory research was planned for weekends to avoid conflict with work.

Adopting a participatory approach to sexual health in Cambodia

Essential components of participatory research in the area of sexual health are trust, mutual respect and the ability to facilitate open discussions about sexual health matters. In a country recovering from its recent traumatic past, where a whole society learned to distrust their neighbour and children learned to spy on their parents, trust is a precious commodity.

Cambodian society is strongly hierarchical and patriarchal. Powerful social norms govern the sexual attitudes of men and women. Hierarchical power relationships and perceived loyalty were important to survival in the brutal Khmer Rouge regime, and continue to be an important feature in Cambodian society today. The powerful exist by the existence of the weak and vulnerable. And, in terms of this sexual health project, as in most patriarchal societies, women are the more vulnerable group.

The fate of a woman is in the hands of her parents choosing the 'good' man and in the hands of the man being knowledgeable and caring. A traditional proverb 'men are gold, women are cloth' does not refer to the fact that women are useful, versatile and essential, but to the belief that women are irredeemably stained by sexual activity while men can be washed clean. After puberty women find themselves in a difficult position. They have the task to make themselves sexually attractive yet at the same time, be on guard against a fallen reputation. The city presents women with many additional dangers: fears of trickery, deception and violence, of rape and of being drugged, caught and sold into the sex

industry. For young female factory workers, the environment they live in is one in which there are relatively few places to be safe from the attention of men.

Men are perceived to be the ones initiating sexual contact and of having sex with sex workers soon after puberty. It is not uncommon for men, both single and married, to talk openly about visiting brothels where they can pay women for sex. It is commonly assumed that the married woman will remain monogamous to her husband and the virginal woman will defend her 'good' reputation. This is a feat harder than it seems in a garment factory, as all those working in the factory can lose their reputation if one colleague is deemed to have done something 'bad.' 'Bad', (in Khmer the closest translation is the word 'broken', as in a broken machine) is a word most often used to describe women who sell sex. Its use is a little like 'slag' or 'slut' in English, a term with an elastic definition that makes it difficult to defend. Thus, with the exception of the heterosexual male and married woman, people outside this social norm face substantial barriers that prevent access to sexual health and educational services.

Learning participatory methods

Learning a new method of working and new active participatory tools placed the research team in an extremely vulnerable position. There was a strong chance that the activity would not be 'right' the first time. Moreover, it will not be 'right' in front of colleagues. Given Cambodia's recent traumatic past, this vulnerable position may have negative associations and in a society where status is of crucial importance, I assumed that it would be an additionally demanding experience to become a student and a novice again. Yet, as I write I am astonished at how eager the research team has embraced new ideas and how keenly they have explored new participatory techniques. As confidence has grown, a willingness to try new ideas, to act flexibly and to take the initiative has flourished. Before long, the research team was very impressed at the creativity and skills of the young people with whom they were meeting.

Some teething problems cannot be denied. How many books describing participatory approaches say it is difficult for the researcher 'to hand over the chalk?' This proved to be an extreme understatement. The research team raised certain questions around this issue: 'What if the participants do it wrong? The participants need us to help them!'. As a result, the command 'leave the group' became a frequent refrain – a non-participatory solution to a problem undermining participation. This was directed at the research team who required sensitive questioning by advisors in the evenings after the participatory research to facilitate a process of self-analysis and reflective practice prior to developing improved communication skills.

'The best laid plans of mice and women'

All negotiations with the factory management for the participatory research were, and indeed, still are, extremely flexible, and dates, times and access were established, verbal approval given, letters written and authorisation gained. However, there were sometimes problems, such as the arrival of a manager from China for example, which meant that the work of the factory had to take priority and the research team was told to come back the following week.

"No. No PLA today. Today the big boss has come from China and we have a rush order, so please come back next week! The additional note takers can go home; the helpers to arrange the food need to send it back; the drivers can have the day off; the pens, pencils, paper back to the office; postpone the translators; cancel the house rented for the day; cancel the room booked for synthesis reporting. Make a new plan, keep all the money for another rainy day!"

It was important to have a schedule for the participatory research to enable a degree of panning and co-ordination. This schedule however, had to be responsive and flexible to

the needs of a given situation and to the daily routines of all involved.

The majority of the research itinerary went according to plan. This involved three days working with groups from each factory. There were four groups per factory, each with seven participants. Three of these were all female and one was all male. The participatory activities took place in a house close to, but outside, the factory gates. Inside the factory it was impossible to establish any privacy or a relaxed trusting atmosphere. One exception to this was where the research team and the participants were talking about their lives in an office next door to an angry boss. This seemed to limit the discussion somewhat.

The schedule for the research was three full days, starting with discussions on working, living conditions and general concerns. Day two examined general health concerns, women's and men's health concerns, knowledge about men's and women's bodies, contraception and conception. Leaflets about infections of the genito-urinary tract were handed out, along with payment for attending[2]. By day three, the conversations were about sex, relationships and their own personal sexual history. At the end of day three the participants were asked for their evaluation and they received referral slips to a local NGO clinic for a free medical examination. In general the participants reported many favourable comments about the activities; only one man did not like drawing naked bodies. Tools used included mapping, transect walks, listing and ranking, matrix design, Venn diagram, seaonality analysis, thought bubbles, causality analysis, role play, sex census and body mapping (see Figure 1).

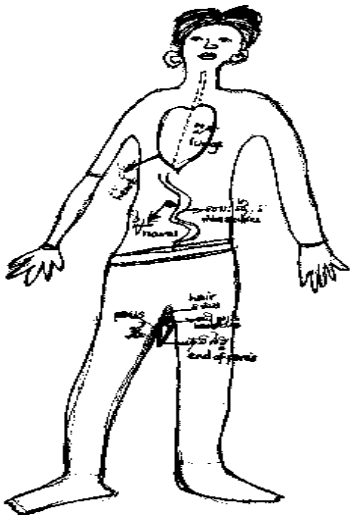

Figure 1. Drawing of male reproductive organs by young men, Factory Y, 5th April 1999

A closed way of opening up

We ran into a problem at the first experience of using participatory methods with a group of young single women. Although the female researchers initially expressed confidence in their ability to talk about sex openly, after all they were midwives, they found themselves unable to ask 'good' women about possible 'bad' behaviour. The tool agreed upon to learn about young women's actual behaviour was adapted for use in Cambodia from CARE Zambia - the Closed Paper method[3].

After discussion with the research team, I stepped in and asked the participants if the researchers could ask them personal questions. The participants agreed without hesitation, but the researchers still remained uncomfortable. In halting Khmer I asked about the young women's sexual relationships. When the scrap bits of paper came in with symbols that represented the replies, the researcher charged with noting down the answers found it difficult to remain quiet and not share the answers with us all.

[2] There were many debates about payments. In this instance, the young workers were missing the opportunity to work overtime. And, as the research shows, they have barely enough money to cover their living expenses. It was decided to respect their time and work with money, as indeed all the researchers were being paid.

[3] The closed paper tool is a method whereby the participants are asked some personal questions and they place a symbol on to a piece of paper in reply. The replies remain anonymous, so a major disadvantage to this method is that there is no discussion.

Her eyes lit up. She went from sitting on the floor to sitting on her feet. The participants remained calm and apparently unperturbed by our flapping.

By the end of this session, the method yielded little in the way of direct information, but it somehow facilitated trust. Many questions poured out from the participants; questions the young women had previously felt unable to ask anyone for fear of gaining a 'bad woman' label. In the following three months of fieldwork, it seems that though this is still a sensitive subject, questions about sex in a personal situation as opposed to a medical setting of midwife and patient can now be asked and responses acknowledged in a supportive style.

Other methods

Methods of body mapping involved drawing around another member of the group and this resulted in much laughter. Role-play turned into team role-play. Often the participants were too shy to speak, but in teams with one person nominated as a spokesperson, other members of their team could whisper questions to ask or suggest replies to make. All were shy but equally, all members participated and enjoyed this approach. At times, hilarity from one group caused a disturbance to another in the adjoining room. Role-play, as with all the methods, was selected to offer the research team and future health providers an insight into the thinking, attitudes and behaviour of the young target population. It was hoped that this would help to identify areas for potential health promotion activities and to enable the young people to practice negotiation through conversation. Often the role-plays resulted in agreement for blood screening or agreement for condom use without a great deal of negotiation (see Box 1). The researchers helped with ideas for a scenario; it is hoped in future participatory activities that the project staff will be more able to empower the participants to take this control and the initiative.

BOX 1
SCRIPT FROM A ROLE PLAY – MEN

Husband wants to use a condom what does he say to his wife?

Moderator:	Who is a volunteer to be a wife? Who is a brave man?
Participant:	I am looking I am not brave!
Moderator:	I like to have the volunteer so that you can explore your own words, can you play as a wife?

Lots of negotiation with the participants before the role-play started

Husband	Now we have 2 children, I am also busy with my job and our life is not so good, I like you to use birth spacing so that you have no problems. I will use a condom what is your idea?
Wife	Up to your decision dear!
Moderator	Any more ideas?
Husband	Don't you think my idea is strange
Wife	Strange or not, this is your business. You may have a bed with other women.
Husband	If you don't mind so I decide to use a condom, I think I shall use, what do you think?
Wife	Up to the man
Husband	Now can we have fuck?
Participant	Don't you think your husband has an infection?
Participant	Do you have infection that's why you want to use the condom?
Participant	Do you have another woman that's why you worry about infection?
Husband	I don't have infection but I want to space the birth. If we have many children it will cause problem to our job. If you have a job with one company and you take leave for delivery your salary will be cut down from $100 to $50 so our life will get down a little.

Cartoon drawings were used to represent relationships and events in a person's life. Drawing was enjoyed and in some groups everyone sat around the paper and added to the story of a girl/boy relationship. The story flowed in a circle with the chatter. Animated discussions took root over how to draw specific parts of the picture, for example, how should the hair of a young woman be drawn; in bunches? Parted? Parted to which side? What colour should the hands be drawn? etc. The drawing had to be *'sa-at'*, a word translated as beautiful, but also meaning clean and smart. The participants were clearly concerned about drawing the picture wrong.

Reports documenting the experiences of such participatory research are very important, but they are difficult to plan correctly. Should they be written on a daily basis? Should they synthesise the research of all the separate research groups? Which language should they be prepared in? At which point should they be translated? Should the final reports be easy to read but include an in depth analysis of young people's complex interpretation of the world around them? What about process reports of how and why and what happened with the use of participatory tools for sexual health with garment workers?

We planned time for reporting but this was too short. Redrawing the visual outputs, reflecting on experiences and translating to English after each session left little room for anything else. Translation was necessary to give appropriate aid with areas that required further probing. Fortunately further funding from FOCUS and CARE allowed us to recruit a consultant who was fluent in Khmer language and skilled in analysis. With support, the research staff analysed and produced their first report. In order to share our experiences of using participatory approaches and to provide a tool which would help with further capacity building, the final report was written in English.

Findings from the process

The project has succeeded in introducing a participatory concept to the project staff. Difficult as it is to measure success, project staff have clearly improved their facilitation skills and gained confidence as advocates for young people. The main concern and pressure throughout has been that of time: time to spend additional project funds was too short as was time for the Cambodian staff to fully understand and adapt a participatory approach before applying it to research. There was also not enough time to analyse the piles of information collected during the study, yet the staff did it and did it well.

A lesson learnt was that the tools needed to be more specific and more time was needed for flexibility. This would enable questions to be asked about what a specific group thought about contraception, what that group's mothers thought; what were the advantages and disadvantages of different methods of contraception rather than just ranking them. The research team had little exposure to experiences of probing; initially activities resembled a question and answer session. Thus while advantages and disadvantages of contraceptives may have been discussed amongst the participants with more experienced facilitation, it was not found to be the case in our first experiences of using participation in research.

Additionally, as it was a needs assessment, bounded by time and resources, specificity of tools would have been more timely and beneficial. Finally, working with 12 groups and using a range of tools, the researchers were able to cross reference and triangulate information learnt. However, due to the flexibility of the researchers approach to a subject, this was a challenging feat at times.

• Future and sustainability

The three factories involved in the participatory research were all invited to send representatives from the management, health staff and factory workers to a presentation with CARE and its local partners. Each factory sent at least two representatives who entered into discussions on the research findings and suggestions for future action. The project staff then visited the factory manager several more times to agree on an action and continued access for CARE and its partners.

At every stage of the process factory management has been and will continue to be actively involved as much as their many work pressures will allow. The factory workers remain interested and enthusiastic to commit whatever time they have free to participatory health activities. In terms of long term sustainability, the future is by no means certain. It is extremely dependent on the growth of the nascent garment industry, the growth and stability of the national and regional economy and the whim of the factory management. The aim is to try and make a demonstrable difference to the smooth running of the factory that would inspire some of the managers and owners to institutionalise improved health services. Managers are supportive with our involvement, one factory manager was proud to a show a potential European garment buyer their renovated health clinic.

Needs identified during the process of the research have resulted in all the factory health staff receiving additional training in STI management and contraceptives, as have the local NGO counterparts. Five factory clinics were renovated and will be intensively supported for six months whereupon the support will be reviewed. Participatory health activities over 2 months per factory with six groups of 15 workers each (4 groups of women and 2 groups of men) will hopefully offer factual information, challenge rumours and lead to a supportive environment for change.

A participatory approach to research is only a beginning of a process. As the project continues, we have time to further develop facilitation and probing skills. Furthermore, we have more time to put into question many of the cultural beliefs that the Cambodian staff continue to accept unquestioningly. Only by coming to terms with the effects of their own cultural beliefs can staff enable the factory workers to gain an insight into the social constructs of gender that perpetuate many a risky relationship. It is believed that components are in place for change. The female workers are in a unique position compared to their grandmothers and mothers; they have the opportunity for independent paid employment, the opportunity for independent living, and an opportunity, however rudimentary, to question social constructs that hinder informed choice. The process of change is beginning.

- **Julie Forder,** CARE International Cambodia, P.O.Box 537, Phnom Penh, Cambodia. Tel: + 853 23 721115; Fax: +853 23 426233; Email: forder@bigpond.com.kh or care.cam@bigpond.com.kh

NOTES

Julie Forder has been working in Cambodia for several years, the last 18 months as an adviser with CARE. She was previously a nurse, midwife, health visitor and social researcher in North East England.

ACKNOWLEDGEMENTS

The research team members who learnt and applied participatory research techniques were: Morn Vann, Medical Assistant and Noun Ren Midwife, Women's Development Association; Pang Phearum and Soch Kuntea, Midwives, Reproductive Health Association, Cambodia; Ros Vantha, Senior Project Officer and Medical Assistant, CARE; and Som Phally, Health Educator, Cambodian Health Education Development.

Kak Thavery and Nob Sothea Rattank of the National Centre for Health Promotion and Soth Sina of CARE were note takers. Independent consultants Pawana Wienrawee, Lim Sidevil and Alexandra Maclean respectively facilitated analysis and a draft report in Khmer, assisted the team to format, edit and print the Khmer language report, supported use of participatory tools and produced an English report on the findings. The project is funded by United Nations Population Fund (UNFPA), the European Commission (EC) and CARE.

REFERENCES

Kaul Shah, M., Zambezi, R., Simasiku, M., (1999) Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents. CARE International in Zambia, FOCUS on Young Adults.

12

Participatory learning and action requires good facilitators - who aren't always around

Andrew Hobbs and Mary Simasiku

• 'Good enough' participatory learning

We believe strongly in the value of new participatory research methods as a way of stimulating high-quality learning of facts and skills, and awareness of new attitudes to improve people's sexual health. Such methods would include mapping, ranking and scoring, 'problem trees', transect walks, time-lines, daily and seasonal schedules, pie-charts, flow charts and Venn diagrams. However, many of these methods require good facilitation, which is not always available.

But if we could put the skills and experience of a good facilitator down on paper (in a book) in an easy-to-understand way, then many more people would be able to facilitate participatory activities. This was our approach to the problem. We accept that a lower level of facilitation skills may reduce the quality of the learning that takes place, but the big advantage is that it greatly increases the quantity of learning. All that is needed is a group, a literate person with the confidence to speak in front of the group, and the book. The quality of learning will be higher if the facilitator has had some training, but even without training, it will be 'good enough'.

The request: a sexual health training pack for use with non-literate young people

This request came from a US NGO, Project Concern International (Zambia). They had part-funded a book of 50 participatory learning activities on sexual health for young people, produced by a Zambian NGO, the Family Health Trust. The book, 'Happy, Healthy & Safe', was targeted at school-going children and youth from ten years upwards. What made it unique was that it was designed to be used by young facilitators rather than adults, with easy-to-follow instructions (scripts, almost) requiring minimal training or facilitation skills. This approach allowed facilitators as young as 12 to lead groups of their peers in activities such as role-play, games and discussions, after an hour's preparation with an adult (older teenagers and trained peer educators needed no coaching at all).

Project Concern saw the need for a similar peer trainer's book that could be used with out-of-school youth possessing little or no literacy. At the same time, the Lusaka Interfaith HIV/AIDS Networking Group, who were working with Project Concern, identified the need for educational materials suitable for religious youth.

So in May 1998, Andrew Hobbs, one of the authors of 'Happy, Healthy & Safe', was contracted for two months to produce a training resource suitable for low-literacy groups of youth attached to religious organisations.

• Participatory research, the ideal approach (or so we thought)

The use of participatory research and the related tools seemed ideal: a participatory, empowering philosophy, a body of techniques that required no literacy, and a track record of use in sexual health promotion. 'Stepping Stones' is the obvious example, with its mix of drama and 'new' participatory methods, as well as participatory needs assessments of

sexual and reproductive health by CARE Zambia.

But even such approaches as these required too high a level of facilitation skills for the group with whom we were working. The plan was to gather a team of young people who led youth groups at their places of worship and train them in participatory research techniques. Then, together, we would develop and trial a sequence of learning activities and write them down in an easy-to-use trainer's manual.

Andrew Hobbs recruited three other facilitators: Mary Simasiku from CARE, an experienced practitioner of participatory methods; Richard Mambwe, a talented young writer and researcher, and Holo Hachonda, knowledgeable in HIV prevention training with religious youth groups.

The young people themselves comprised three young women and seven young men (two Muslim, eight Christian) aged 18-23, who were recruited mainly from youth groups linked to the Interfaith network. Exceptionally talented and committed, they worked on the programme one or two days a week for expenses only, even during the World Cup!

We began with three days of non-residential training. The aims of this induction were to enable participants to:

- explain the basic facts of sexual health;
- challenge attitudes and beliefs that can lead to poor sexual health;
- explain what their religion teaches about relationships, sex, health and self-esteem;
- agree the topics to be included in the learning pack;
- facilitate participatory activities;
- conduct basic research using participatory techniques; and,
- pre-test and evaluate participatory learning activities.

The first half of the programme concentrated on information about sexual health, plus religious attitudes to sexual health and HIV (including a gender awareness session from a Zambian nun who runs a women's refuge). The second half looked at different ways of raising these issues and preventing HIV with religious youth groups, looking at the use of participatory methods in particular.

Mary Simasiku introduced a range of methods including problem trees (flow charts), unfinished drama sketches, picture codes, mapping, seasonal and daily calendars, Venn diagrams, ranking and scoring.

The induction programme was somewhat over-ambitious, but succeeded in setting a friendly, informal and tolerant atmosphere and establishing the basis of participatory research.

Together we decided the topics to be covered in the manual:

- values;
- recognising risk;
- communication skills;
- positive and negative peer pressure;
- sexual relationships;
- biological facts, where to get help;
- how to talk to parents; and,
- how to live positively with HIV.

After the induction, participants were asked to go back to their youth groups and conduct a simple piece of participatory research, using techniques such as mapping, problem trees and focus groups. This allowed them to practise the techniques and provided information about the target group of the learning pack. They returned the following week with maps, diagrams and discussion notes which confirmed the group's choice of topics for inclusion in the manual and the suitability of participatory methods.

How we wrote the book: a cycle of action and reflection

We met for each Thursday every week for the next seven weeks. Richard and Andrew would draft instructions for two to three participatory activities, sometimes drawing on their own experience and sometimes adapting learning activities from other books. The young people used the instructions to lead us all in the activity, then we reviewed the activity and instructions, and developed their facilitation skills through coaching. We tried to make the Thursdays fun for the participants.

Before the following Thursday, the young people went back to their own youth groups and facilitated the same activities. When we met again, each person reported how last week's activity had gone at their church or mosque and suggested improvements, before moving on to the current week's activities.
During the time between Thursdays, Richard and Andrew researched and wrote the background biology and theology for each activity, and Andrew re-drafted previous instructions. Twice during this period we met religious leaders from the Interfaith group and went through drafts together. Their response was encouraging. These review meetings probably helped to allay the leaders' fears and build their confidence in what the young people were producing, to the extent that they approved material which presented condoms in a positive light, which was previously unheard of in religious approaches to sexual health promotion.

As the Thursdays hurtled by, something peculiar started to happen. Instead of the young people using activities devised by Richard and Andrew, they began to devise their own. For example, on how to talk to parents about boyfriends and girlfriends, they came up with two possibilities, which we reviewed together before choosing the best. This was a two-minute unfinished sketch of a mother outraged by her daughter asking a question about pregnancy. There were suggested discussion questions, a role-play to practice broaching difficult subjects with parents, and a final discussion. It was as good as anything in a modern training manual.

The team also became able and confident facilitators. They contributed to the background information, helped to brief an illustrator, planned and starred in the book's photographs, and chose the title ('Treasuring The Gift: How to handle God's gift of sex'). During the last session we discussed how the book could be disseminated - they were impatient to get out there and show other young people their book.

Three months after the Interfaith group gave the go-ahead, they were presented with a 142-page photocopiable draft, containing 18 learning sessions supported by 47 pages of background information. The book's message was that the religious 'Plan A' of 'no sex without marriage' can be good for sexual health, but we also need a 'Plan B' of harm minimisation.

The book's methodology: drama, rather than mapping, diagramming, ranking, scoring or calendars

Together we devised and adapted more than 30 participatory learning sessions. The 18 that we selected to go in the book are overwhelmingly drama-based, in which groups are asked to watch unfinished, open-ended drama sketches, to devise sketches themselves, or to role-play difficult situations. The drama stimulated discussion, and the role-playing allowed practice of skills (see Figure 1). The 18 sessions were combinations of 21 drama-based activities and 18 non-drama activities.

The non-drama activities include short bursts of teaching (e.g. about HIV infection and prevention, sexually transmitted diseases and religious teachings), problem trees, brainstorming, games, drawing, a picture code, quizzes, hot-seating and a ranking exercise. In hot-seating, one person takes on a role, sits in the hot-seat and is questioned by the rest of the group. They improvise their answers, based on their idea for the character, so gradually, through the questions and answers, a picture of the character and their behaviour are built up.

We had not planned it this way. The drama and role-playing won out because drama is very popular in Zambia as a pastime, as an educational method and as entertainment. Therefore the young facilitators were more confident with drama than with other methods, and needed less coaching in how to facilitate it. But unfamiliarity was not the only reason for using fewer 'new' participatory methods, such as problem trees and ranking and scoring. Our final product had to be a book that could be used by facilitators with little or no training in participatory methods, in meetings where no more than two hours would be devoted to the activities, and that seemed to rule out all but the simplest methods. Let us say that the essence of participatory research is to let the group's concerns set the agenda, with the facilitator suggesting the most appropriate tool for the task in hand. If the group needs to

listen to its quieter voices, there are suitable activities; if it needs to become aware of the varying needs and beliefs within the group, again there are tools, and so on with observation, analysis, decision-making and planning.

In this situation, a facilitator needs to have the confidence to 'go with the flow', without knowing what he or she might be called upon to do in an hour's time. The facilitator needs experience of a wide repertoire of activities, the creativity to invent some new ones, the judgement to choose the right activity at the right moment, plus all the usual group facilitation skills. None of this comes quickly or easily. By the end of the two months, our team of young facilitators were capable of such facilitation, but by then we had run out of time, because we had run out of money.

The strength of the approach of 'Treasuring The Gift' is that a facilitator only has to read the instructions aloud, and things happen. The book is very easy to use, the instructions are simple and a young person with only a few days' training can use it successfully. Indeed, during pre-testing, some young people who were not part of the programme and had had no training at all, used the book to lead groups. The strength of good participatory facilitation, its creative, improvisational quality, can't be written down, and we needed something that could be written down.

Figure 1. Three of the 'Treasuring the Gift' development team – Richard Mambwe, Mizzeck Banda and Albert Canteen, in a role play about negative peer pressure [Photo: A. Hobbs]

• Conclusion

We could have approached our challenge in other ways, and there are no short cuts to success. Our solution was a compromise. There is a danger that entrusting facilitation to young people with a low level of skill and experience can do more harm than good. We hope that evaluation will assess this risk, but the pre-testing that was part of the book's development showed no sign of any harm.

We have written this article as the opening of a conversation. We would like to hear what others think about the following questions.

- How important is good facilitation for good participatory research?
- Can we put good facilitation down on paper without killing it?
- What can we do about the shortage of good facilitators?
- What experiences are there of unskilled facilitation doing more harm than good?
- What are young people's experiences of facilitating participatory research?

- **Andrew Hobbs,** 20 Broadgate, Preston PR1 8DX Lancashire, UK. Email: andhobbs@btinternet.com and **Mary Simasiku,** CARE Zambia, P.O. Box 36238, Plot 3020, Musi-O-Tunya Road, Woodlands Shopping Centre Lusaka. E-mail: care@zamnet.zm

13

Moving beyond the 'KAP GAP': A community based reproductive health programme in Eastern Province, Zambia

Gill Gordon and Florence Phiri

• The problem

Over and over again, we read that populations have a high level of knowledge of contraception and AIDS but this does not necessarily translate into safer sexual practice. We know that information alone is rarely enough to bring about a sustained change in behaviour and we must address the underlying determinants of behaviour by creating more supportive and enabling environments. Gender relations, socio-economic power, support and self-esteem are key components of these environments. Often the response to this so-called 'KAP[1]-GAP' is a recommendation for more research to inform more targeted, persuasive messages, disseminated through social marketing or campaigns.

Until recently, family planning programmes have largely reached married women in their child-bearing years and sexual health programmes have reached men with sexually transmitted infections (STI). With the AIDS epidemic, condom use may now be reported as being for contraception *or* STI/HIV prevention. Adolescents have been at best provided with Family Life Education at school and/or local puberty instruction on how women and, occasionally men, are expected to behave. Older people rarely have access to sexual and reproductive health (SRH) services that meet their specific needs. Often there are separate service delivery points or days for each SRH service. Other SRH needs such as sexual violence and abuse, abortion and emergency contraception, sexual information and problems are often only provided through private practitioners, if at all.

This fragmentation of services, education and user groups has made it more difficult to achieve behaviour change and therefore improvements in SRH. Many men are concerned about the effect of hormonal contraceptives on the body and suspicious of their partner's motives for using them. There is also a tendency for men not to tell their partners when they have an infection and it is widely felt that condoms are associated with disease and improper sex. Many family planning providers see condoms as a backup method for married women before the pill or contraceptive injection kicks in and tend not to promote them for prevention of infection.

This article describes a more holistic SRH health project in the Eastern Province of Zambia. It focuses on participatory approaches used, gender issues, male involvement and the integration of SRH issues at community and clinic levels. The article aims to demonstrate the opportunities and challenges faced by a government programme that uses participatory approaches in its everyday work to achieve the vision committed to at the International Conference on Population and Development held in Cairo in 1994.

The community based distribution (CBD) project

In CBD programmes, men and women are selected by the community to be trained as family planning workers. Until recently, these programmes have aimed to motivate people to plan their families and have distributed

[1] KAP stands for Knowledge, Attitude, Practice; and refers to the idea that if people have knowledge and positive attitudes, they will change their behaviour.

condoms, spermicides and pills to people in their neighbourhood. The Zambia CBD project began in Eastern Province in 1994 and is being implemented by the Planned Parenthood Association of Zambia (PPAZ) and the Ministry of Health of the Government of Zambia with technical assistance provided by Options Consultancy Services and funding from the UK Department for International Development (DfID). The project has trained 220 men and women to work as CBD agents in six districts.

As a process project, the team has had the resources and flexibility to test out innovative approaches. These focus on ways to actively involve all community members in project design, implementation, monitoring and evaluation, to integrate SRH issues, to address the underlying determinants of behaviour and to foster NGO, CSO and government collaboration. Participatory activities include participatory research; 'Stepping Stones'[2] activities; interactive use of visual and performing arts; non-directive counselling and regular sharing sessions on progress between all community, NGO and government stakeholders.

The CBD agents

CBD agents are men and women between 24 and 55 years old, mainly farmers with around seven years of schooling. They live in their own villages and serve a catchment area of around ten kilometres radius. They are provided with a small financial allowance, bicycles, contraceptives and locally produced brochures, flipcharts and booklets[3]. They receive a four-week training which includes interpersonal communication skills, counselling, group work and participatory skills, producing simple drawings and role-play or songs as discussion starters and some Stepping Stones activities. Emphasis is placed on attitudes and behaviour, particularly in relation to gender, age and sexuality. Content includes contraceptives, condoms, STI, HIV/AIDS, abortion and emergency contraception, sexuality, managing logistics and planning their work. During the training, the CBD agents explore their own ideas and values in relation to SRH in the same way that they will later assist the communities. They work in separate sex and age groups and then share their ideas in plenary.

Participatory group work

Rural Health Centre staff supervise the CBD agents and support them in community work. They begin by explaining the project to the chief and headmen. A full community meeting is then organised where the work of the CBD agents is explained and people are invited to meet the CBD agent in six peer groups to discuss their needs and how they might like to work with the CBD agents. Peer groups comprise adolescent boys and girls, young men and women, and mature men and women. At the first meetings, the CBD agents facilitate participatory activities aimed at identifying the groups' idea of good SRH and priority problems; analysing the causes and consequences of these problems, looking at what they have tried, the achievements and challenges associated with the problems, and what actions they wish to take. The groups then hold in-depth discussions on priority problems using pictures, role-play, song and information sharing.

Work in separate peer groups is a key principle of the process. This gives people privacy and safety to explore their own values and feelings about their sexual lives without domination, sexual overtones or cultural expectations of age or gendered behaviour. The importance of this principle was reflected in Ghana when peer motivators began a group discussion with men and women on what helped sex to be pleasurable. The men launched into an excited sharing of the importance of physical beauty and female compliance with their desires and why women were so ready to have sex after minimal persuasion. The women were silent and angry. When it was suggested that the men and women go into separate groups and meet after some private discussion, the women

[2] Stepping Stones, written by Alice Welbourn, is a guide for a series of learning sessions on SRH, communications and relationship skills. It used participatory drama and drawing and is designed to be used with peer groups in communities.

[3] CBD Booklets on related issues can be downloaded from Options' website: www.options.co.uk. :

unanimously agreed that their partners' refusal to allow them to use contraception and fear of pregnancy was their major barrier to pleasure. When the groups met again, the women explained this to the men and a helpful discussion followed.

Counselling

Non-directive counselling is very important in sexual health programmes. It provides an opportunity for clients to explore their situation, to talk openly about their feelings and needs, to be listened to with empathy and confidentiality and to find ways of meeting their needs. The CBD agents provide counselling to men and women of all ages, separately or together on request. Many clients seek counselling following the peer group meetings. Male agents counsel women as well as men and visa-versa. Men rarely have an opportunity to discuss these issues. In Zambia, staff and communities reported that having time to express their anxieties about contraception and relationships was key to their acceptance of this service. Men with few resources have voiced fears that contraceptives will enable their partners to form relationships with richer or more virile men and leave them. As a result of the counselling and group work, there have been noticeable changes. Some men have stopped taking their wives' pills with them when they travel to prevent them from having affairs and instead are supporting them to take their pills correctly.

CBD agents were sometimes accused of having affairs because they counselled clients and provided contraceptives in a private place without their partners if they wished. This was most likely to happen with male agents and female clients. However, women have also accused the agents of providing condoms to partners and encouraging them to have affairs. As a way of tackling this problem, CBD agents have encouraged people in regular relationships to attend joint counselling together, whilst respecting the client's right to individual, confidential counselling.

Experiences of participatory group work

In the first participatory activity, people worked in separate peer groups and then came together to present their diagrams and findings at an open public meeting. This is normal practice in participatory research and the team did not perceive any risks with it. The young people used this opportunity to accuse the older people of failing to give them sex education and adequate support materially and pressuring young people to have sex with them. Women also expressed their dislike for some of the local customs relating to sexuality. These customs were supposed to be kept secret outside initiation teachings and not be discussed in public or between men and women. Initially the facilitators felt that the experience had been positive because usually submissive people were able to express their needs and feelings in front of those with decision-making power. However, CBD agents later discovered that there had been some negative repercussions in homes after the discussions, and also that some participants felt they had been misled in being asked to share their ideas with those from different generations and the opposite sex when confidentiality had been agreed.

Following this experience, the community leaders asked the CBD agents to meet with people in separate peer groups, without directly sharing their discussions in public meetings. They suggested that the CBD agents should act as mediators or negotiators between groups. They would share ideas from one peer group to another where relevant through role-play, stories or pictures, which would trigger discussion. The groups could then discuss any problems without feeling accused by a community or family member. This would prevent direct confrontations which older men and women found humiliating and responded to defensively.

For example, in Zambia, women complained that some men did not allow them to use contraceptives or refuse sex and this made it impossible to space births. The CBD agents created a set of picture cards, which they used to tell a story about a man who threw away his wife's pills and beat her. They asked the

men's group whether this situation occurred in their community, what were the good and bad points about it, why a man might behave this way and what the consequences might be. They were then invited to re-tell the story in a more positive way according to their perceptions of the situation. This was followed by a discussion on what would help men and women to talk about and agree on sexual decision-making.

This process has worked well but it does not actively encourage communication on sexual matters between the sexes or generations. However, in a participatory evaluation, people reported that men and women were talking more openly about sexuality because they had learnt to talk in peer groups and had greater understanding of the perceptions of others. Teachers, parents and grandparents reported that they now understood that adolescents are having sex in spite of traditional teachings and that they need condoms to protect themselves.

The CBD agents in some communities were trained to use an adapted 'Stepping Stones' process. This process provides several sessions with activities aimed at building trust, confidence and comfort with talking about sexual issues and preparation of drama in separate peer groups before presentation to the other groups. People develop role-plays for analysis in their own discussions and then adapt them for presentation to older or younger people and to the opposite sex. In this process men and women have been able to meet together and discuss in a frank way sensitive issues like condom use among married couples. For example, in one group, women said that they did not mind using condoms, but the men should wash first because they tend to be very dirty from working on the farm. They pointed out how dirty the condom had become when one of the men demonstrated its use.

• The impact of the CBD project

In a participatory evaluation of the Zambia CBD project, the top three positive changes reported by both men and women in equal numbers were good child spacing and its associated benefits, fewer STDs and happier sexual relationships. This indicates that there has been some integration of the components of SRH in the perception of the community. Negative changes reported by fewer groups were the side effects of hormonal contraceptives, poor condom disposal and more sexual activity outside marriage because of reducing the fear of a negative outcome. A few groups mentioned more marital conflict because women were making autonomous decisions about contraception. Men comprised of between 40-60% of the clients and people appreciated that peer group discussions were held in separate peer groups.

The most difficult group to reach was adolescents, mainly because of disapproval from older people. They did not attend meetings and asked for contraceptives to be supplied on the roadside at night. Older men and women also thought that the programme was not relevant to them as people past childbearing.

This was partly because the CBD project had initially been introduced as a family planning project which distributed contraceptives. Those who were not expected to be sexually active did not see its relevance. This highlighted the importance of introducing the project as an integrated SRH intervention that helped people to identify their own needs and design activities to meet them, rather than to vigorously promote the use of contraception to all.

The CBD agents themselves felt that the project had brought many positive changes in their lives and also some negative ones. The men felt than they had become more 'caring and kind' rather than 'brutal and rough' as they were before'. Some said that their relationships with their wives had improved and they no longer had girlfriends as well. Some women said that they were better able to assert themselves and some had made good marriages as a result of the project. Both men and women reported that they were now able to talk about sexuality with groups and individuals and help people with a range of SRH problems. The difficulties of being a CBD agent included the hostility of some parents, partners and religious leaders towards their work and a lack of respect at times because they deal with sexuality.

- **Lessons learned from training staff to use participatory techniques and 'Stepping Stones'**

Working with groups

Facilitating participatory activities in sexuality and gender is a new skill for many health and development workers and they need an opportunity to explore their own values and feelings through participatory processes before they can facilitate others to do the same in a non-judgemental way.

In single sex and age group discussions, people have a degree of common understanding of their situation and shared values. However, this should not be overstated. There is a danger that group closeness encourages people to affirm norms and build consensus rather than express perhaps minority views and harsh realities. For example, a person who is attracted by people of the same sex may find it difficult to even introduce the notion of same sex activity and may receive a very negative response.

Gender and generational issues

Men tend to find it more difficult to talk about personal feelings and experience than women and this can have a major impact on the process. Many women will readily share their vision of a happy sexual life and their experiences of problems such as male abuse and unwanted or unsatisfying sex. Men tend to distance themselves from their personal experiences and feelings by talking about men from a different age group or context. In Stepping Stones training, women performed a role-play showing a day in their own lives as women based on collective experience, whilst men performed a role-play about a behaviour pattern in culturally distinct farmers in a remote rural area.

On the other hand, some men and women seem able to capture the situations, body language and behaviour of the opposite sex perfectly in role-play. Some male CBD agents in Zambia acted the part of women in oppressive or distressing situations so realistically that it brought tears to the eyes of the audience. This appears to show an ability to understand the opposite sex, although this does not necessarily reflect a desire for change.

In one training, men felt that their drawings were too explicit or 'rude' to be shared with women. Members of the young male CBD agents group in the Zambia CBD project used their own slang and showed explicit scenes in a role-play and were reprimanded and asked to apologise by the older men.

Facilitation becomes more difficult when men and women come together to share their ideas. If women's presentations are based on their own lives and men's are not, women can feel aggrieved that they have 'bared their souls' and made themselves vulnerable whilst the men displaced their own concerns on to other groups. Men can tend to feel defensive when women present pictures of 'men behaving badly' and they react by generating an intellectual debate on the validity of the women's perceptions. Situations such as these are difficult for facilitators to handle and people who have personally experienced distressing situations may feel very upset.

A large group of men and women of different ages meeting together can exacerbate the problem because only the most vocal tend to speak and the whole ambience is one of challenge and 'a battle of the sexes' rather than listening and empathy. Arguing with women about sexual matters can be an arousing game for some men and they can use it to maintain control over women, especially young women. In Zambia discussions between generations were also confrontational in some cases, with older people eager to maintain the traditional culture and young people wanting to 'modernise'.

Some solutions to these difficulties

Conflict between groups is not in itself a bad thing; it is a normal part of life. Suppressing conflict limits growth and often has negative repercussions. We can use conflict constructively to build understanding and move things forward in a positive way. However, this requires training and practise in conflict management.

An important principle of all SRH work is that people are not pressured or manipulated to disclose personal experiences or feelings unless they are ready. If peer groups have different degrees of willingness to share personal feelings, it is not helpful to make those who are less willing feel inadequate. They need time, encouragement and supportive facilitation.

In a training with participants from South Asia, we found it helpful to divide the whole group into smaller groups of men and women, perhaps four or six. People in the small groups are asked to take it in turns to talk about their ideas for five minutes while the others actively listen and empathise. After each person has finished, the group members feedback the most important thing they have understood. When everyone has spoken, people identify the similarities and differences in their perceptions and how they can work together to improve things. This practice in expressing ideas with and listening to the opposite sex in an unthreatening way resulted in a significant increase in discussions between men and women.

When peer groups include two or three generations, this method could help adolescents and parents or older relatives to talk together more easily, with groups deciding who should sit together (in Zambia in-laws are forbidden to discuss sexual matters together.)

• Conclusions

The integration of the different components of SRH makes programmes relevant to all community groups. Men and women, boys and girls, need opportunities to work in separate peer groups in a private space to identify their own priorities and actions.

Sharing of needs, feelings and suggestions for improving their sexual lives between peer groups can accomplish a number of goals, depending on how it is organised. Programme workers can act as mediators between groups to share ideas in a non-threatening way. Small group sharing between men and women, young and old allows people to practise talking together about sensitive topics and develop mutual understanding. Public presentations from peer groups can act as a powerful advocacy tool for change at community level and result in dramatic change. For example, in an evaluation of Stepping Stones in Uganda, the older men's group put on a drama about a local man who demanded sexual favours in return for employment and requested him to stop this behaviour. He was publicly shamed and it was reported that he had since ceased harassing women. Drama by adolescent girls about harassment by sugar daddies had the same effect. (ActionAid, Redd Barna, Kahcae, Aegy 1998) 'The teeth that are close together can bite the meat': a participatory review of Stepping Stones in two communities in Uganda. SSTAP, ActionAid. London, UK).

Men and women, young and old may respond differently to participatory work in SRH in context specific ways. It is essential to continually review and adapt the process as it goes along in order to find the most helpful approaches for all those involved.

Facilitation skills are play an essential role for safely and successfully using participatory processes in SRH. They take time and practice to acquire. Programmes should aim to design participatory processes that match the level of skill of the majority of facilitators in order not to undermine facilitators and put everyone at risk.

Opportunities for individual, couple or family counselling are crucial in SRH because many personal issues and feelings will not, rightly, be discussed in a group situation.

- **Gill Gordon,** Reproductive Health Alliance Europe, 443 Highgate Studios, 53-79, Highgate Road, London, NW3 1TL, UK. Email: ggordon@rhae.org **and Florence Phiri,** Centre for Development Studies, University of East Anglia, Norwich, NR4 7 OJ, UK. E-mail: F.Phiri@uea.ac.uk

NOTES

Gill Gordon has provided technical assistance to the Zambia CBD project through Options Consultancy Services since 1994. Florence Phiri works for the Planned Parenthood Association of Zambia as CBD/Regional Manager, based in Chipata, Eastern Province. Options provides technical assistance on all aspects of reproductive, sexual and maternal health programming.

14

Gambian experiences with Stepping Stones: 1996-99

Matthew Shaw and Michelle Jawo

• Introduction

The Gambia is an Islamic, Anglophone country situated in the middle of Senegal in West Africa. Its population is about 1.1 million, spread along the banks of the River Gambia. The main economic activity is subsistence agriculture (groundnuts, millet, livestock) and fishing. HIV prevalence is quite low at about 2% of the population and as yet no-one has publicly declared themselves to be HIV positive. Therefore many people are doubtful that HIV really exists. Moreover, many men are suspicious of Family Planning (including condoms) and this view is strongly supported by some Muslim clerics who believe it to be against the Koran. For economic reasons, men like to have many children, if they live in a rural area. In one area, the total fertility rate for men is 12.0 compared with 6.8 for women; men achieve this impressive fertility through polygamy (Hill and Ratcliffe, 1998-9). The practice of male and female circumcision is widely practised, as in other North African countries. For women, this usually consists of a type 2 circumcision, where the clitoris, clitoral hood and labia minora are removed without closure of the vagina.

What is Stepping Stones ?

The 'Stepping Stones Gambia' project is a collaboration between five organisations; The Gambian Department of State for Health, ActionAid - The Gambia (AATG), Gambian Family Planning Association (GFPA), Medical Research Council (MRC) - UK and the World Wide Evangelisation for Christ Mission (WEC). The partnership began in 1997 to adapt, implement and evaluate the original Stepping Stones workshop programme (Welbourn 1995). This is a manual describing a series of participatory exercises designed to facilitate HIV prevention by encouraging a gender analysis of sex and its context. The workshops then move into assertiveness training, encouraging participants to be assertive about their feelings and dialogue with their partners, focusing on communication and relationship skills. It was originally designed for use in Sub-Saharan Africa, although has since been adapted and used in many different countries across the world. It operates around a workshop structure, with separate peer age and gender groups.

As outlined in the beginning of the Stepping Stones manual, the traditional ABC HIV prevention message (Abstain, Be faithful, use Condoms) is impractical. Abstinence is undesirable to most people, except in certain situations, such as after childbirth, and when not abstaining, condom use is unacceptable. It is unacceptable within marriage because of its contraceptive effect and generally, because it carries the message that one partner suspects the other of infidelity. When husbands have to support several wives, they may not have enough money to support them and their children adequately; providing an incentive for wives to seek help elsewhere.

Stepping Stones Gambia started because it was felt that the programme could help villagers develop more sensitive solutions to the problems of HIV prevention. One reason we have found the programme effective is that participants meet in age-sex peer groups: usually young men, young women, old men, old women. In the Gambia, (as in many African countries) this is the only forum in which sexual matters can be discussed relatively freely. Most villages are organised in these groups anyway and these are known as *kafos*.

The workshops last for about 10 one-day sessions. Within this period, the *kafos* meet twice to perform 'frozen pictures' or tableaux to each other. The way the workshops are arranged encourages assertiveness between groups of people. Peer group members can have sensitive conversations within their group, but can select what messages they give to other groups. This culminates in the final community workshop where each peer group makes a 'special request' to the whole assembled village, participants and non-participants alike.

Adaptation

Following discussions, the workshop programme of this original Stepping Stones programme was adapted in a number of ways and a Gambian Stepping Stones manual will be published shortly. Although very similar to the mother manual there are some changes. Certain exercises, such as those involving alcohol, were omitted, because the Gambia is an Islamic country, with very little alcohol. It was decided not to use video because electrification is rare in rural villages and very few organisations have portable screening facilities.

Entry into the village was a big problem. We often found men suspicious that this was a secret birth control programme, so we presented it as an infertility prevention package. Sexually transmitted infection is the biggest cause of infertility, and the way to prevent infertility is the same as to prevent HIV. This infertility approach proved to be very popular and we included exercises on 'questions and answers on sexually transmitted infections' and the causes of infertility as well as advice on how to conceive, drawing from the South African adaptation of the same training manual (Jewkes and Cornwall 1995). Most villagers did not know about the fertile period in a woman's menstrual cycle, even though delay in conceiving can often cause problems.

Many communities often guess well what development workers want to hear and play along because they think this will improve potential benefits. So we started the programme with a blind matrix scoring exercise on health priorities. Facilitators used the fact that they represented a coalition of organisations to prevent people guessing their area of interest. We did this to try and assess how close the villagers' agenda was to ours. Sexual health problems tended to fall in the top 5, usually sexually transmitted infections, sexual weakness or HIV. In the last case, HIV, villagers felt they were ignorant about something they had gathered was an important issue.

Sometimes the men were concerned that when we took the women away for their separate meeting we might inject them with Depo-Provera[1]. So it was important for the participants to know that every group did exactly the same exercises. The one exercise in the original manual where women do a slightly different activity was modified.

We also added body mapping of sexual 'turn-ons' and 'turn-offs'. This was to enable discussion of the difficult subject of female circumcision and orgasm. However female circumcision was not an urgent priority for the villagers, although there were other problems to do with the sex act itself. Exercise 'M' from the original manual (about will-making) was not included in our first adaptation because in the Gambia, the extended family has a responsibility to care for the bereaved. However we are now planning to include a modified version to try and have an impact on gender inequality in inheritance, which can contribute to poverty and financial dependence on sexual partners.

The basic structure of the workshop programme remains similar to that of the original Stepping Stones programme. An additional inter-peer group meeting was added so that the groups meet three times before having the final community meeting. More recently we have altered the exercise preparing for the final community workshop. Next time we will ask peer groups to produce a Group Action Plan based on 3 changes that they would like to see. They are then asked to select one of these changes to be presented as a 'special request' to the community. This means that the 'special request' is not necessarily the *most* important change that

[1]A contraceptive.

each peer group would like to see, but may be the one which is *hardest* to achieve without the support of the rest of the community. Also, we found that preparation for the post workshop review has been weak. Yet this is most important for sustainability as it may lead to continued community mobilisation.

Timing of the programme.

Programme timing was very important. The Gambia has three rainy months every year, when all villagers are preoccupied with planting. The original manual suggested spreading the workshop over 9 weeks. Although the dry season would be the obvious time to run the programme, a PRA exercise suggested that many people migrated to the urban areas during this period. Therefore the pilot study took place in the harvest season as a compromise. Thus we could only work one day a week on the farmers' day off. This was the second time the GFPA teams had run the programme, and (although they felt pressed for time), they managed to cover all twenty six sessions in 10 days. We would recommend 14 days as the ideal length of time required.

Pilot evaluation

The MRC ran a pilot evaluation of the programme in the GFPA areas. This included a fieldwork report (process evaluation), interviews, focus groups and a KAP (Knowledge, Attitude, Practice) survey[2]. We also planned a participatory evaluation although unfortunately, because of some confusion, the peer groups did not set their own targets for the changes they would like to see. The facilitators were asked to record the output of the workshops each week. However they tended to write down absolutely everything that happened. This made them less effective as facilitators, and made it very difficult to produce a field report at the end. The second time round, the exercises where it was important to record things, were clearly identified. When the Gambian Stepping Stones manual is produced it will include preprinted reporting forms for photocopying, designed to make a report readable when put together.

The pilot villages were small hamlets with populations of 158 and 250. About half the population over 17 participated in each community. More women participated because of the population structure of the villages. Shortly after it began, MRC field workers interviewed 140 people (participants and non-participants) chosen at random from the two villages involved in the programme, and two control communities. The questionnaire included knowledge questions about the transmission and prevention of sexually transmitted infections and HIV, as well as questions about attitude. We also tried using 'secret ballots'. We believe this technique was invented by a local anti-circumcision NGO (BAFROW). Ballot forms were give to each member of the peer group. When the facilitator read out the question participants had to mark a triangle for yes, a circle for no or nothing for 'don't know'. At the end of the session participants, folded their ballot sheet and put it in a hat. The ballots were therefore anonymous but the peer groups were known, enabling us to analyse the responses by age, and sex (see Box 1).

BOX 1

SOME EXAMPLE OF QUESTIONS USED IN THE SECRET BALLOT

- Have you talked to your partner about sexually transmitted infections in the last year?
- Are you responsible for any children under 16?
- If so, have you discussed the bad side of sexual relationships with these children in the last year?
- Can a man or woman be infected with a sexually transmitted infection but not have any symptoms?
- Can a man have a discharge from his penis without having sex?
- If someone has a sexually transmitted infection which is treated and cured, is it OK to resume sex with their partner?
- Is a woman most fertile on the day after her menses?
- Can sexually transmitted infection make a woman barren?

[2] A KAP survey is a formal questionnaire, based on a fairly rigid model, which tends to focus on health education.

• Results

Six weeks after the programme finished, we returned and conducted 50 key informant interviews, seven focus groups and repeated the KAP survey (140 interviews) and secret ballot. We will repeat these shortly, when a year has passed since the original intervention. Comparison of the 'before and after' results showed that intervention villages had gained a good understanding of the issues.

The KAP survey showed a significant increase in knowledge about sexually transmitted infections after Stepping Stones for women. However this is biased by the fact that young women are proportionally the largest participating group. When further analysed by age, the old women *kafos* usually gained least, maybe because many of them are no longer sexually active and the issues are less personally relevant. Men showed a strong trend in improved knowledge, but because they knew more in the first place, these changes were not significant. In most cases improvements could be seen when participants and non-participants from the Stepping Stones communities were included, even though workshop participants tended to keep their new knowledge to themselves rather than go out and share it. We did not set our expectations very high; e.g. knowing at least one way in which HIV can be transmitted earned a point. However at baseline, only half the women could answer this question. Next we will examine the men's responses using more stringent criteria.

In particular we found a much greater awareness of the risk of sexual activity in general and an appreciation by men of the importance of supporting their wives financially. The KAP survey supported the interviews in these results. For example 11/28 (39%) of women considered themselves to be at risk from HIV before the programme compared with 35/43 (81%) after the programme. Women in polygamous marriages were 9.7 times more likely to consider themselves at risk. These quotes are taken from recorded interviews.

"I have changed very much because I used to play about. I would sometimes leave my wives for a week . But when I joined the programme I stopped that. (in-depth interview - young man).

"We the women have also reduced irresponsible sexual behaviours and unnecessarily travelling ….…. to be able to meet our needs" (focus group discussion - young woman).

The survey showed about half the respondents had ever had sex outside of marriage.

- Participants who had been involved in the condom familiarisation exercise were much more comfortable about using condoms. It was remarkable that the issues to do with sexual activity could be discussed openly in the whole village, which greatly impressed our government colleagues.
- Several key informants told us that wife beating had stopped completely in the Stepping Stones communities. This was because of improved dialogue between husbands and wives and also, through peer pressure. Many men were now too ashamed to be seen beating their wives, having agreed that wife beating was wrong at the final community meeting.

Most of the role-plays produced during the programme included wife beating in one way or another.

Drawbacks

Unfortunately the secret ballot was not successful; participants did not understand that a 'no' response could be correct and all it showed was that participating in Stepping Stones makes you more likely to vote 'yes'. We realised this because we got strongly positive responses to all questions, no matter whether they contained very negative or positive statements. This contradicted information collected using different techniques. However we will continue to develop this technique because we feel it could potentially be an appropriate monitoring tool to include in the manual. We also feel that an anonymous monitoring tool is important given the sensitivity surrounding change in sexual behaviour. In future, we will emphasise that a

'no' response can be correct and structure the groups more like focus groups, thereby restricting their size and probably keeping the membership of these groups the same from one occasion to the next .

Collecting information about behaviour has been our most difficult challenge. Before running the programme, we identified all the official condom distributors in the area and asked them to monitor the number of condoms they distributed to members of participating communities. However we found that very few participants got condoms from these sources, most of them using their own (limited) informal channels. These channels were almost impossible to identify before the programme, so we had no baseline data. Following the programme, each peer group chose to identify a distributor. These distributors refer clients to each other but keep the details of the people they supply confident. Although we supply the condoms at the moment, the distributors are variable in keeping records for us. We use a pictographic form, but the distributors often lose or forget to complete them. However although the demand for condoms from one individual is not the same as condom use, (people may take condoms to sell), demand does seem quite high and is probably higher than before the programme. In one village (population 250) 600 condoms have been given out in 12 months.

"Now if some men ask women for sex the women will ask them if they have a condom and if he says no then she will refuse." (in-depth interview- young man).

"According to my observations there are changes of behaviour, attitude and awareness, especially [with] the youths towards safer sex, with an increase in use and demand of condoms to avoid infections." (in-depth interview - young man non-participant).

Operational issues

Running the programme gave us several problems in terms of logistics and human resources. Firstly, it was difficult to find enough women staff to be facilitators. Secondly, between 1996 and 1998, the programme was not completed six times in ActionAid areas. This was due to logistical reasons and from lack of enthusiasm from the communities.

Because they are posted evenly across their development areas, it proved difficult for the ActionAid community development workers to come together in one community at one time. It was a challenge for co-ordination and required extra fuel, (some staff having to travel up to 70 kilometres to attend the workshops). This was made worse because we failed to sensitise the middle managers at ActionAid, who therefore did not prioritise the programme in their action plans. Since these activities were budgeted at the national, rather than the area level, they were not included in the area work plan. Therefore area managers received no credit or incentive for programme completion. In all the pilot areas, the programme was disrupted by routine facilitator movements, or other trainings. This prevented consistent attendance in the Stepping Stones villages - which lost momentum.

In the GFPA area, community facilitators were employed. They managed to complete the workshop programme three times with substantial logistical support from the MRC and financial support from ActionAid. Initially they were salaried but this is unsustainable because of the intermittent and seasonal nature of the workload, and since our donors do not pay salaries. Transport was a problem: even though the Gambia is a small country, many villages have no public transport at all. Therefore the facilitators depended on MRC vehicles to get to the workshops, incurring a considerable fuel bill. Now facilitators are paid for three days per workshop, (one day's travel to the village and one day's return).

• Conclusions and future plans

In summary, we have found the following.

- The programme is popular and the infertility prevention approach is acceptable
- Changes were shown in the following areas; risk awareness, dialogue with

partners and peers, attitude to condoms and a reduction in wife beating.
- Young women are the main benefactors because they are less knowledgeable at the beginning
- Old women are less likely to gain knowledge or discuss in the community
- Secret ballots need further development.

Currently we are examining how to expand the programme sustainably, using some small UNDP funding.

We will pursue 4 strategies.

1. Stepping Stones as part of integrated rural development.
Following an EDF[3] programme, all government extension workers are now organised into Multi-Disciplinary Facilitation Teams, (MDFTs), co-ordinated from the Department of Community Development. These teams combine all the extension workers from different government departments by locality, and have been involved in participatory needs assessments of all the communities in their areas. In a bottom-up planning process, these needs assessments are combined to make (electoral) ward development plans, which will become the agenda for the new area councils due to be elected next year in local government reforms. Sexually transmitted infections are already a high priority in the first plan to be collated. This matches our own initial matrix scoring.

These MDFTs have now been joined by the NGO sector, including ActionAid and GFPA. Next year the MDFTs will expand to new areas. We hope to integrate Stepping Stones fully into this process, so that, should reproductive health problems be identified, the programme will be offered.

2. Freelance facilitators
The problem with a lack of women staff remains. Therefore the 'employment' of dedicated community facilitators will continue. Although they are paid essentially on a per diem basis, their terms and conditions have been modified to include a monthly 'retention fee' given if their earnings fall below a certain point, along with a savings scheme. This is because many facilitators had difficulty explaining their irregular employment to their families, who had heightened expectations of the amount of support they should give to the household. We hope these arrangements will attract more skilled women back into the workforce, and that as the popularity of the programme increases they will be increasingly contracted as trainers by outside agencies.

3. Non literate facilitators?
We would like to explore the possibility of a 'talking book', in which the instructions for the exercises are recorded on audio cassette in local languages so that facilitators do not need to be able to read. Another possibility is to make closer links with the ActionAid REFLECT[4] adult literacy programme. There are many similarities between the two manuals and the material in Stepping Stones could be a good base for the adult literacy exercises.

- **Matthew Shaw** and **Michelle Jawo,** Medical Research Council (UK), The Gambia, Email: mshaw@mrc.gm

ACKNOWLEDGEMENTS

This work was generously supported by ActionAid The Gambia and the Medical Research Council.

REFERENCES

Hill, A.G. and Ratcliffe, A.; Men's fertility and reproductive strategies in rural Gambia: 1998-9, *Harvard/MRC male fertility study:* Narrative report on fieldwork and preliminary analysis Jan 1998 - Feb 1999

Welbourn, A.; Stepping Stones – a training package on HIV/AIDS communication and relationship skills. *Strategies for Hope*, London. 1995

Jewkes, R. and Cornwall, A.; Stepping Stones – a training package on HIV/AIDS communication and relationship skills. *CERSA, MRC and Planned Parenthood Association of South Africa,* 1998

[3] European Development Fund.

[4] REFLECT Literacy Manual ACTIONAID London 1996.

15

A new approach to evaluating a peer education programme for sex workers

Kate Butcher, Sumi Baral, Krishna Bista and Rajendra Adhikary

• Introduction

Two years ago, a peer education programme was developed in Nepal to equip urban sex workers with the skills to help their fellow workers practise safer sex, to update their own knowledge on risks from unsafe sex and to provide a forum for sex workers to discuss imaginative approaches to safer sex beyond the condom. Initially 18 sex workers, all women, attended and this number has increased as the programme has developed. The women are keen to become peer educators because they are interested to learn about health issues and enjoy increased status among their peers because they give out condoms and assist other sex workers in the use of local services for sexually transmitted diseases.

While some of the sex workers who attended were able to read and write, the majority were illiterate or semi-literate. In the spirit of good participation, the workshop was adapted accordingly, using picture codes, symbols and stories to promote communication. However, one problem remained. How could we evaluate the success of the programme with regard to the desired objective of reducing risky sexual behaviour? Furthermore, how could the women evaluate their success as peer educators? Diaries were out of the question because of limited literacy, and besides, if discovered, they could be incriminating for women whose occupation was a secret from their loved ones. Verbal accounts were likely to be inaccurate and forgotten and women could not be expected to report to the programme on a daily or even weekly basis.

Mala

As a result, we developed an innovative and attractive alternative: the 'Mala' system. 'Mala' means necklace and is a popular accessory for all women. We decided to provide each participant with a set of different coloured beads, and during the workshop, and, in consultation with the group, allocated different colours to different activities relating to their role as peer educators as well as their own sexual practice. The activity relating to each colour is listed below.

- Red; asked a client to use a condom and he agreed.
- Green; accompanied a girl to the clinic.
- White; asked a client to use condoms and he refused.
- Yellow; gave a fellow worker condoms.
- Black; avoided intercourse, had safer sex.
- Blue; had sex without a condom.

The idea was that after each activity, women would thread the appropriate colour on to their mala. Each month the situation would be reviewed.

At the monthly review meetings, project outreach workers sit with the peer educators individually and look at their necklaces checking that the colours represent the agreed activities. Since the sex workers/peer educators themselves allocate the colours and activities, this has not proved too difficult. Results and queries are noted in the record book and subsequently discussed with all the peer educators together.

Figure 1. Diagram of a 'Mala'

• Impact

The Mala is a unique self-assessment tool which has helped women to monitor both their own activities as commercial sex workers as well as their role as peer educators. Because it is highly visual, patterns and trends are easy to identify. There has, for example been a marked increase in condom use among the peer educators and their peer sex workers over the monitoring period. However there are usually several blue beads where women have sex with regular clients and/or boyfriends and do not wish to use condoms. Non penetrative sex initially never occurred, although in the last 6 months it has appeared in two women's necklaces.

Monitoring of the system has been increased in the last 6 months and it has become clear that, with regular support and supervision, the Mala system can be an effective, attractive and enjoyable way of evaluating an otherwise difficult field of work. Not only can sex workers measure their own success and activities, but they also have an attractive accessory at the end which can be understood by no-one, other than their fellow peer educators and project supervisors.

• **Kate Butcher, Sumi Baral** Primary Health Care Project,/GTZ, P.O. Box 1457, Kathmandu, Nepal., **Krishna Bista**, Director of the HIV/STD Project, University of Heidelberg, Germany; **and Rajendra Adhikary,** Centre for Development Activities, Pokhara**,** Nepal

NOTES

This article was first published in *PLA Notes* 33 October 1998 as an extract. It is being included again with this special issue on Sexual and Reproductive Health as it offers an effective way of evaluating a sensitive area of work and it is hoped that those who may have missed this item previously will be able to learn from the authors' experiences.

16

Introducing participatory methods to HIV prevention workers in the Southwest United States

Kim Batchelor

Introduction

In recent years, the demographics of the HIV epidemic in the United States have changed. What was once a disease that largely affected white gay men now disproportionately affects the poor, people of colour, the young, and women. Sexually transmitted diseases have historically had most impact on these same populations. Because of this, and the fact that prevention efforts have often centred around knowledge-sharing alone, participatory learning and action (PLA) methodologies offer an opportunity to make HIV prevention a more innovative, effective, and collaborative effort.

The philosophy behind participatory research was presented in workshops for HIV prevention workers in Dallas, Texas and for health educators taking on HIV as a new issue in New Mexico and Arizona. The latter training occurred in the Pojoaque Pueblo in New Mexico. Many of the prevention workers who participated in the trainings were indigenous to the populations they work with. In both workshops, careful attention was paid to the collaborative nature of participatory research, and both began with Edstrom and Nowrojee's 'Steps of Unlearning[1]'. The workshops incorporated several activities, including mapping exercises, Chapati diagrams, causal flow diagrams and problem solving techniques.

Mapping the body

Participants engaged in body mapping in both sites, illuminating several issues around the use of this method. In one site, when participants were asked to divide into gender-specific groups, one transgendered person, born biologically male but living as a female, did not know in which group she should participate. She was given the option to choose and chose to participate with the females, mapping the male body. This situation illustrates how important it is to consider transgendered/transsexual individuals when doing gender-specific exercises and groupings.

Participants in Dallas mapped erogenous zones; those in New Mexico mapped organs associated with the birth process and those affected by sexually transmitted diseases. For participants in both workshops, desire and sensuality came into play during the mapping exercise, expressed by both the female and male participants. The women mapped males with broad shoulders and chests and flat stomachs. Men mapped the 'ideal' woman with large breasts and lips, and (in one case) blonde hair. The exercise in one site was made interesting by the fact that the group of males mapping women was largely made up of gay men. The map of the female produced by this group replicated some of the same idealised female attributes as might usually be seen in an all-straight male group.

Following the body mapping activity, the women processed what they saw that the men had drawn and the men discussed what women had mapped, eliciting strong emotions on both sides that called for good mediation skills. The exercise illustrated the persistence of stereotypical body images, such as large breasts and penises, for example. The groups then discussed body image as a barrier, especially for females, in the prevention of transmission of Sexually Transmitted Diseases (STDs)/HIV and how this exercise could be

[1] Eldstrom, J. and Nowrojee, S.,(1997) *Visit to Sri Lanka: Report on a PRA workshop for sexual health needs assessment*, International HIV/AIDS Alliance, London, UK.

used to address this barrier directly. In New Mexico, participants saw how various health issues might be analysed through the use of body mapping, including cancer and 'appropriate and inappropriate touch' for children.

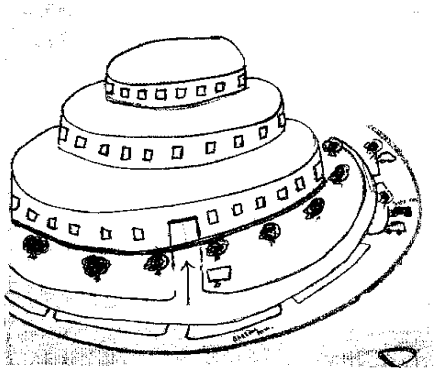

Figure 1. Facilities mapping exercise: Pojoaque Pueblo, New Mexico, United States

Facilities mapping

Participants from both sites participated in 'facilities mapping,' a technique used in the workplace that is also known as 'hazards' and 'social' mapping. For this activity, in small groups, one individual acts as the 'describer' of a facility, such as a health clinic. Others in the group act as different types of 'mappers.' First, the general mapper sketches a general design of the facility as the describer dictates. After rooms, corridors and waiting areas are all drawn, the general mapper uses arrows to describe the usual 'flow' through the facility. The social mapper uses red and green stickers to identify where 'leaders' are (red dots) and where people gather (green dots). The final mapper uses a green marker to indicate 'safe' areas and a red marker to indicate 'hazardous' areas, however those terms are defined by the describer.

Process dynamics

The describer being different from the mappers allowed the participants to understand what it's like to cede control and taught them to be specific in their instruction. For mappers, it encouraged listening skills. A note-taker in each group also described what s/he observed during the activity. Feedback from the two sites revolved around how the activity can illustrate barriers within organisations and can identify the perceptions of both staff and clients of the agency in terms of what's the same, what's different etc.

At the Pojoaque training, a group of five individuals from various American Indian tribes pondered the exercise for a time before asking if they could map something they would like to see, rather than what already exists. They mapped a building where all services could be centralised, a building of three levels constructed as a round structure (see Figure 1). The round structure was important, according to the group's reporter, so that 'you won't get boxed into a corner.' The significance and preference of the shape of the circle versus the square came up at various times during this training. The group also saw the centre of the second level as a place to carry out rituals, and then discussed the possibility of creating a jogging track on the bottom around the outside of the structure to encourage physical activity. Although I had thought of the activity as a way to describe what already exists, the creativity expressed by this group also raised the issue of using mapping potentially to describe 'desire': what can be as well as what is.

• Lessons learnt

These two trainings illustrated that participatory research holds promise as an innovative way to elicit information and develop and evaluate programmes, especially in the health field. In the Dallas workshop, a caution emerged in that fascination with PRA tools may result in superficial use of them without true collaboration with affected communities. Some participants wanted to use the visual techniques as interventions alone. Given those cautions, my initial experience with training on participatory methods for HIV prevention and other health workers gives some hope that this community collaboration can occur. Strategies to continue to inform and motivate front-line health workers are necessary if the approach is to take root.

• **Kim Batchelor,** University of Texas Southwestern Medical Center, 400 S. Zang, #520, Dallas, TX 75208 United States. Email: kimberly.batchelor@email.swmed.edu

17

Mapping the effects of vasectomy

Ann Sturley

• Introduction

In a rural district of Nepal, as part of a year-long study of reasons for non-use of contraceptives, group sessions were held with men who had undergone vasectomy[1]. Hand-drawn outlines of a man's body were used to focus the men's discussion about their experiences. A main result of this exercise was the finding that men believe that vasectomy involves severing a vital channel, causing problems wherever this channel goes in the body. This article describes the process of using body mapping to explore the men's experiences of vasectomy. It illustrates just one example of how participatory techniques may contribute to deepening our understanding of the issues involved in the acceptance of contraception, clearly an urgent matter in countries such as Nepal.

Background

Many local Nepalese beliefs about the side effects of contraception do not coincide with the biomedical view. Instead, contraception, sexuality and reproduction are all viewed in the context of the social, cultural, and religious belief system. I sought to find the extent to which non-use of contraception is due to the incongruence between what people are told about contraceptives by health professionals and what they themselves experience or believe. Semi-structured interviews were held with medical practitioners, past or present contraceptive users and all adult members of a sample of families. A survey was carried out with 215 married women of reproductive age (15-49) and their husbands, 165 men[2]. The final activity was an exchange of information with the community to correct misinformation about locally available contraceptives and HIV, to ask directly what the villagers thought about some preliminary findings and to allay any remaining fears and misconceptions about the research. This article explores one aspect of the research, men's post-vasectomy experiences.

• Men's experiences with vasectomy

Focus group discussions with sterilised men were convened in each of the nine wards of one village of Myagdi District in Western Nepal. Each focus group began with an apology for talking about such a private topic, "*for we* (my assistant and I) *are like your sisters and daughters and should not mention such things, but we really want to understand your own, true experiences with vasectomy*[3]". Immediately after this, we unrolled a hand-drawn outline of a male body. We asked the men to describe their operation, giving each a different-colored marker pen to show the location of their incision (see Figure 1). Each

[1] The study took place in Myagdi District, Western Nepal, from May 1996 to April 1997. Myagdi was chosen because the 1991 Fertility, Family Planning and Health Survey showed respondents had a high level of knowledge about contraceptives and where they could be obtained, and yet reported average contraception use. The research sites were two villages and one section of the Myagdi District Centre.

[2] There were fewer male than female respondents because many men in this district work abroad, following a long-standing tradition of joining the British and Indian Gurkha regiments. Now men are more likely to work as unskilled labourers in the Middle East or Europe, the U.S. or Japan.

[3] I would have preferred to have had equally skilled male and female assistants, but this was not possible. We did have a local male assistant to help with the focus groups, but he did not have facilitator skills. My research assistant, Hema Pun handled the situation with impressive tact and persistence.

man in turn was asked to relate what he had experienced during the 'operation'. The men were encouraged to focus on the drawing, lessening the embarrassment of discussing this topic with two women. Then each was asked whether he had experienced any effects since the vasectomy. Finally, the groups were asked about other effects mentioned elsewhere in South Asia or by those previously interviewed for this study. We then asked about Sexually Transmitted Diseases (STDs)/HIV. Finally, we showed samples of all the contraceptive methods available in Nepal, including a diagram of how male and female sterilisations are performed and explained in detail about HIV using a flip chart produced by Save the Children/US. At the end of each session we provided refreshments, then walked home and translated and transcribed the tapes. The next day we began the process again. Each group was scheduled to begin early in the morning, but we often waited several hours for the farmers to finish their morning chores. Once we began, the process lasted from three to five hours.

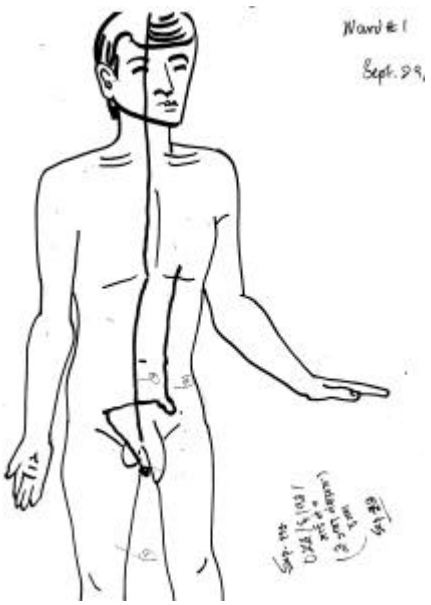

Figure 1. Post-vasectomy effects explained with body mapping

After a few minutes of embarrassment, the men spoke openly about the operation and about the effects they felt it had had on their body and their lives, some commenting that this was the first time anyone had taken an interest in their post-vasectomy experiences. As they spoke, they indicated the connections they perceived between their current condition and 'cutting the *nasa*[4]'. The following quotes from the focus group discussions illustrate some of the issues that concerned the men.

"First they put on anaesthetic. There are many nasa*, but they cut the* nasa *the seed goes in, with a blade. Pulled the 2 ends together and tied them. Gave me medicine for pain, also for healing. I could walk then, but after 3 days my balls swelled. I got fever, and my seed came out on its own. It was impossible to work for 1 week. Blood came out from the incision. I had to be carried to town. The doctor checked me, gave me tablets and capsules. Told me to eat meat, strength-giving foods, for 15-20 days. I got well but still now the inside of my left leg is sore when I go downhill, and I get backaches. I think the* nasa *goes to the left leg, that's why it's weak. When there's much rain or sun, I get this. For the last 2 years I've had this. Backache too".*

"If I have to do hard work like with a hammer or axe, my sitting bones get sore, first the left side then the right side. When I have no hard work and get good food and rest, this doesn't happen. My eyes are weak. I think it's the nasa. *I can see at a distance, not close up. My balls swelled for a while, until the incision healed, but nothing else happened there where they cut".*

"Slowly my eyes are getting weaker and weaker. The operation did it, by cutting down there. The nasa *goes to the eyes. I get colours in front of my eyes. My seed can't go out; instead it goes to my eyes. The place where they cut is fine but the nasa is confused, it's not in the right place. For this reason the operation affected my eyes. Also this is why I'm weak. I get effects on the left side -- sometimes to the underside of my foot, and sometimes to the top of my head. This is how I got sick.* (Drew a line up the left side to left shoulder, then left eye). *" Because of this, my blood is insufficient, my eyes are getting weaker and weaker. My caste are supposed to bow down and touch the feet of those of high*

[4] *Nasa* is a Nepali word that approximates the English 'vessel', in that it is used for blood vessels, lymph ducts, nerves, the vas deferens and possibly the channels of acupuncture. Whenever *nasa* was mentioned, we prompted the men to draw the *nasa* on the outline of the man's body.

caste. My eyes are so weak I've even touched the feet of Damai" (lower caste than his).

"Before the operation, all my seed would come out. After cutting the main seed nasa*, now the seed goes in the small branch* nasa*. Because of this my wife has bad effects. When we had sex, seed used to go out forcefully, now it takes a long time. Because of this my wife is affected, because of less seed".*

"My seed used to be thick, but after cutting the nasa *it's thin. When going to my wife's 'house,' I get sick - backache. It causes more sickness to the man, less to the woman. Because the* nasa *was cut. Sex used to make my wife warm, feel well. Now it's thin, doesn't make her feel good. The doctor can't do anything for her, she just gets weaker".*

"For me sex is not much different but it is very different for my wife. When our wives talk together they say the wives of men who were operated on are thin. They say that women get sick after having sex with these men. In the evenings we talk, husband to wife, and wonder if this is what makes us weak. Probably it's due to the operation that she's weak, because her face looks sickly. She was fine before".

"Women with very hot bodies need sex a lot and get thin (after their husbands undergo vasectomy). Cold bodied women don't need much sex and get fatter".

"It's a big sin. To stop children who would have been born, to make one's wife thin, to make your own body thin. One man had two sons, then had the operation. Both sons died, and he then had no heirs".

"Uncastrated goats must be offered to the gods, not castrated goats. We are like castrated goats. It is sinful for us to do puja *(make religious offerings)".*

The main effects described by these men are as was reported in the previous South Asian studies of experiences with contraceptives in South India and Sri Lanka (Nichter 1989a, 1989b) and Bangladesh (Maloney et al. 1981). No such study had been conducted in Nepal. These effects may be grouped into seven main patterns.

- Generalised weakness mentioned as a result of every contraceptive method, but for different reasons. A lack of staying-power, such as needing food immediately when hungry, needing warmth immediately when cold, mostly post-vasectomy, was a new twist found in Myagdi.
- Sexual problems such as impotence, lack of 'force' of ejaculation, increased or decreased sexual desire.
- Other physical symptoms, from eye weakness to leg pains.
- The wife getting thin, weak, and sick because she no longer receives the man's seed as nourishment, with condom use as well as after vasectomy.
- Religious offerings not working because the man (or woman) offering them is no longer whole.
- The sinfulness of not allowing children that god would have given to be born; this in turn causing existing children to die and other misfortunes.
- Hot and cold body types reacting differently to the different methods.

What had not been evident in the previous studies, however, was the importance of the *nasa* that is cut during the vasectomy. The use of body mapping clearly showed how and why the vasectomy caused these effects. The similarity between charts of the energy channels used in Chinese acupuncture and these men's drawings is striking. Is this mere coincidence?

Aside from the context of different belief systems, the side effects experienced in rural Nepal may differ from those described in the West at least in part because of sending inexperienced doctors, who are eager to volunteer because of the monetary compensation, to perform vasectomies in mobile 'camps'. Though some vasectomy failures may be explained by men not using condoms for the requisite number of ejaculations (to assure there are no sperm left), we met couples with two or more children born post-vasectomy. Staff at one vasectomy camp told stories of inadequately trained doctors they had seen cutting a blood vessel or nerve rather than the vas, or making a several-inch incision because they could not locate the vas. Villagers who have heard of one or two

such cases are less likely to undergo the vasectomy themselves.

• Lessons learnt

Using this graphic tool has several advantages. The group can see a visual image while they are discussing, making clear where and what is being described. They are less embarrassed than if they have only each others' and our faces to look at, especially as in this case where women were interviewing men on such a sensitive topic. The researchers also have a visual record of the event in the drawings.

The meaning of anatomical terms varies from person to person, especially in a country with so many languages and dialects. This exercise makes evident what is meant, and also circumvents an attempt to seek a one-to-one correspondence between anatomical terms in two languages. This became clear in another exercise, when we asked for anatomical words from head to toe while pointing to prepared posters (a fully dressed boy, then medical charts of bones, muscles, and internal organs), supplemented on occasion with freshly butchered water buffalo organs. If we had merely used a list of English words, for example, we would not have discovered *tegeltuk*, meaning the space at the back of the knee joint, for which there is no corresponding word in English.

We did experience some difficulties with the mapping exercise, however. The villagers were illiterate, and thus their lines were not necessarily where they wanted them to be; drawing is not practised as an art here. There was a reluctance to draw on top of anyone else's line. This was especially evident with the women's groups, when we asked them to draw the uterus, they drew circles, each one next to the last. The lines, therefore, aren't to be taken as precise descriptions of the location of the *nasa*. Because the outlines stopped at the top of the legs, the men were less likely to draw the *nasa* going to the legs. An outline of the entire body could work better, but it needs to be large enough to show the location of the incisions.

A danger with this, as with any group process, is learning from others in the group. Here we saw the men 'learning' from others in the group that their vasectomy caused sexual problems and impaired vision. Our nodding or remaining silent may have been perceived as agreement. For this reason we felt it essential to discuss contraceptives and STD/HIV at the end of each session, and to return to the villages after the survey and discuss the research findings and misconceptions.

• Conclusion

In conclusion, this paper has shown how the use of body mapping tools allowed us to transcend the limits of biomedical concepts and vocabulary in exploring men's experiences with vasectomy. Hopefully this example will lead others to experiment with similar techniques.

• **Ann Sturley,** Project Director, The Healthy Living Project, UCLA Center for Community Health, 10920 Wilshire Boulevard, Suite 350, Los Angeles, California 90024-6521, USA. Email: asturley@ucla.edu

ACKNOWLEDGEMENTS

With thanks to Andrea Cornwall for encouraging me to write this, and for her article on body mapping (1992) which inspired me as I planned my research. A Fulbright Study Abroad grant funded the research, and an East-West Center fellowship supported my doctoral studies.

REFERENCES

Maloney, C., & Aziz, K.M.A., and Sarker, P., (1981). Beliefs and Fertility in Bangladesh. *Dacca: International Centre for Diarrhoeal Disease Research*, Bangladesh.

Nichter, M., & Nichter, M.. (1989a). Cultural Notions of Fertility in South Asia and their Impact on Sri Lankan Family Planning Practices, in Nichter, Mark, ed. *Anthropology and International Health: South Asian Case Studies.* Dordecht: Kluwer Academic Publishers.

Nichter, M., & Nichter, M.. (1989b). Modern Methods of Fertility Regulation: When and for Whom are they Appropriate*?* in Nichter, M, (ed). *Anthropology and International Health: South Asian Case Studies.* Dordecht: Kluwer Academic Publishers.

18

Evaluating sexual health services in the UK: adapting participatory appraisal tools with young people and service providers

Martin Westerby and Tilly Sellers

• Introduction

In 1997 Trent Regional Executive of the UK National Health Service funded a project called 'Evaluating Sexual Health Services: a Community Approach'. This project was based in the South Humber Health Authority area in Northern England. This is a largely rural area, but with two large towns, which has a history of relatively high local rates of teenage pregnancy and where sexually transmitted infections continue to be a real threat to young people's sexual health. The project worked with health service providers and young people to evaluate local sexual health services and built on several years experience gained whilst developing participatory appraisal tools and techniques with young people in order to learn about sexual health issues from their perspective.

Young people in the South Humber region defined a sexual health service as 'somewhere that young people can go for information or advice about sexual health or where they can get contraception'. This wide definition meant that informal services, such as youth centres and outreach projects, were included in the evaluation, along with more formal services such as government family planning clinics. After finding out what young people meant by sexual health services, the project worked with them to find out what they thought would make 'successful' sexual health services. Consistently prioritised were criteria under the headings of confidentiality, privacy, positive staff attitudes, locations that young people could easily get to, opening hours which were suitable for young people, a good mix of services and no cost for users.

Having found out what young people thought was important for a sexual health service to work for them, the project offered participatory evaluation training to service providers who wanted to work with young people to evaluate their own services. Initially, some service providers were sceptical that a participatory approach would work. However, all hoped that by building a working and trusting relationship with young people, and by using indicators developed by them, this type of evaluation would have a positive impact on their services.

20 service providers undertook training in participatory appraisal and evaluation from 13 individual services. Seven of these participants were from GP practices, three were youth workers, four were community support team members, two were nurses, two were managers, one worked for a voluntary agency and one was a member of the local library service.

Altogether, over 300 young men and women between the ages of 13 and 21 years, in either mixed or single sex groups, gave their thoughts and ideas about local sexual health services. Approximately 150 of these were accessed in local senior schools, 50 in colleges and 50 in youth centres. A further 50 young people were accessed by the trained service providers as part of their normal jobs, including a number who were in local authority care. As the evaluations continue and develop independent of the project, this total continues to grow steadily.

A whole range of participatory tools were used during training and subsequent evaluations. Tool adaptation and creation, along with non-rigid use of tools was very much emphasised

throughout the whole process. Four of these tools are highlighted below. The first three are examples of young people and workers adapting tools to suit a particular situation. The last one is a traditional tool which a group of young people used to illustrate something important, and which had an outcome not expected by the facilitator.

A timeline/trendline

One of the service providers who had been trained in participatory evaluation by the project worked at a rural youth centre. She had seen that numbers of young people using the centre were steadily dropping. This was a concern because the youth centre was one of a very limited number of places that local young people could go for sexual health information or just to talk about issues in confidence.

Initial discussion with some local young people seemed to suggest that the attendance at the centre had decreased primarily because of intimidation caused by increasing violence and aggression amongst some of the members. The youth worker used a time/trendline (see Figure 1) to explore the level of conflict and aggression at the centre and to see whether there was any link between this and the other activities.

It is noticeable that the line indicating conflict and aggression reaches its highest points during peaks of other physical and social activity. An example of this can be seen during the initial scramble for equipment; whilst sports are taking place; because of unresolved disputes at the end of the evening. Some of the conflict taking place at the same time as other social interaction was thought to have carried over from school, or to be drug/alcohol related.

The youth worker was able to act on this information, using further solutions suggested by young people to reduce the potential for conflict, aggression and violence at the centre. This improved the environment so that young people felt safe enough to return and use it as a resource to improve their sexual health.

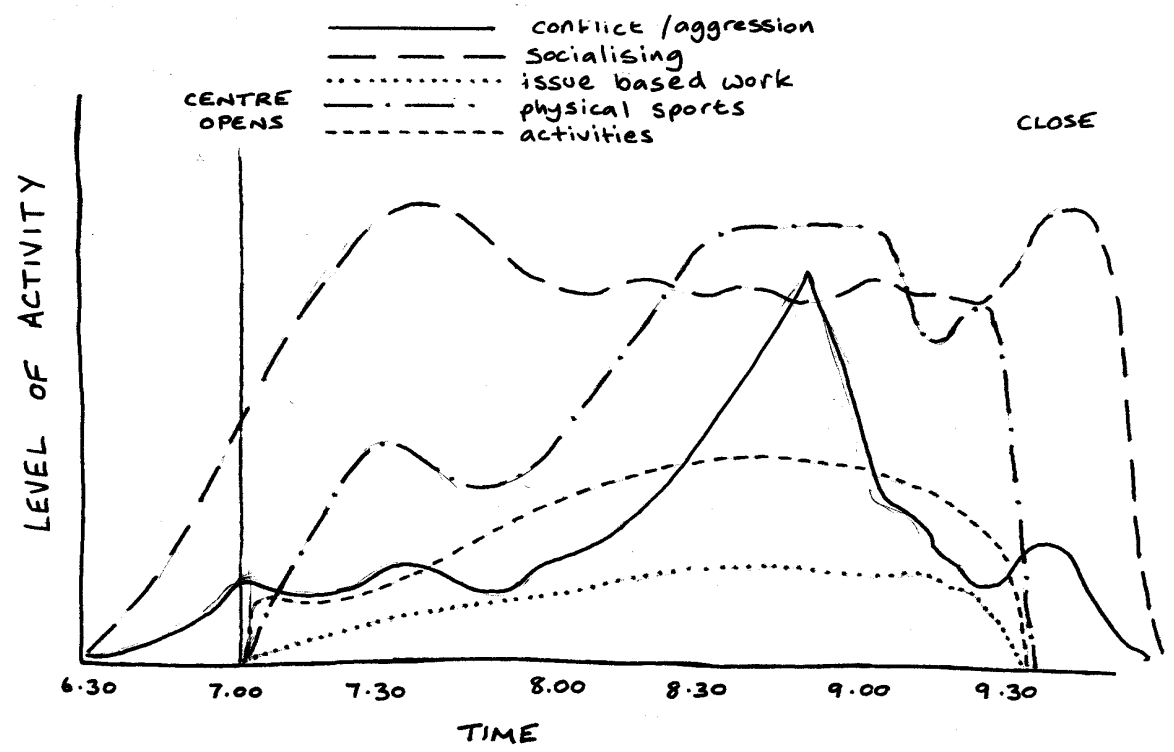

Figure 1. Time/trendline exploring levels of conflict and agression

A barriers wall

Working in a school, a group of young people came up with this visual method of highlighting and addressing barriers to accessing existing sexual health services (See Figure 2). They made a 'wall', using a large sheet of paper and different sized self-adhesive cards for 'bricks'. The cards could be moved, replaced or enlarged several times during discussion. Each brick then represented one specific barrier to using a local service, in this case a government clinic which they felt was particularly inaccessible. Types of barriers included: being embarrassed or scared; not having the skills/information to use a service; not knowing what to expect when using a service; lack of privacy or confidentiality; and not knowing that the service exists.

The group of young people talked about the visual tool they had created. They said that separate walls could be built for different services. The higher the wall, the more the barriers. Large barriers could be represented by more than one brick, or a larger brick. Therefore it is important to have different sized adhesive cards to use as bricks! They demonstrated how the bricks can be taken out of the wall as solutions are found. For example, as a solution for not knowing what to expect when visiting a service, the young people suggested that visits could be arranged by the school, or that service providers could come and talk to young people, either at school or in youth centres. They also suggested that where young people are embarrassed or afraid to use a service, service providers should encourage them to bring their friends with them for moral support.

Using this tool, young people can literally 'knock the wall down' or knock holes in it, perhaps leaving only the barriers which they feel are not significant enough to prevent the service being used. It was recognised that this tool could also be used to monitor how young people feel about a particular sexual health service as changes are made in response to the evaluation.

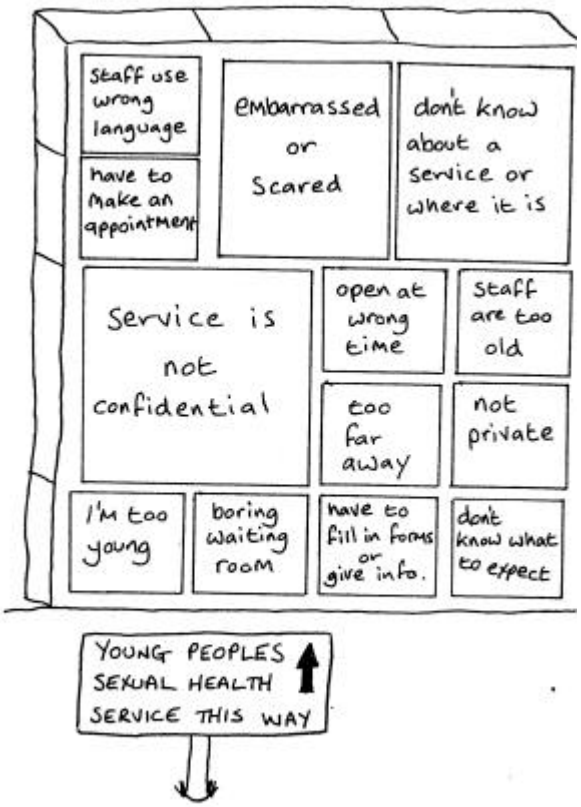

Figure 2. A barriers wall

A time-clock

Young people used this tool to show the times during the day when they would be able to use a sexual health service. It was produced by a group of young people during a youth club session who were asked to find a way to show when services for young people should be open and available for use. No further instructions were given, and the facilitator left the group to come up with something of their own.

After discussion, the group drew a round clock face, marked on the hours and split the clock into 12 segments. In this example they chose to look at the twelve hours between 8:00 am and 8:00pm on a school day (see Figure 3). Later they drew another time clock which indicated when young people would be free at weekends.

In each specific segment they wrote and drew what they do during this period of time,

sticking a 'tick' in any segment when they felt that young people would be able to use a service. They then went on to give more details, verbally, about why they could use the services at these times. For example, the young people suggested that they could only use services in their spare time, or when they could easily justify to parents where they were. This explains why they said that one ideal time to use a service would be during the period between leaving school and arriving home in time for their evening meal.

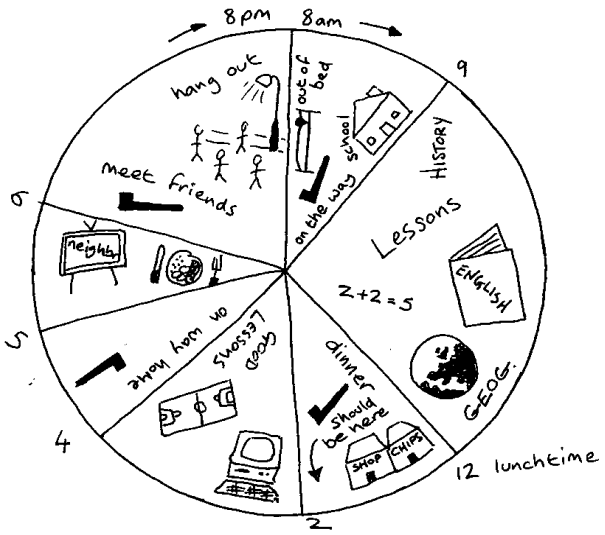

Figure 3. Time clock showing the times young people would be available to use a sexual health service

Pairwise ranking

In this last example, a small group of students, visited at a local college, had used a number of participatory tools to come up with a list of criteria for 'successful' sexual health services. The facilitator wanted them to use pairwise ranking to discuss which of their five general criteria (good staff, confidentiality, privacy and discretion, appropriate opening times and good location) were most important.

As can be seen from the illustration (see Figure 4), the group found that it was too simplistic to complete the exercise as the facilitator had planned, because several of the criteria are related and inter-dependant. For example, one of the young people said, 'How can we choose between good staff and confidentiality? One of the qualities of good staff is that they are confidential!' Similarly, another said that it was not possible for them to distinguish which was the most important between good opening times and location because, 'It's no good a service being open at the right time if it's a long way away.' And, 'It could be right next door, but that's no good either, if it's only open when we're at school.'

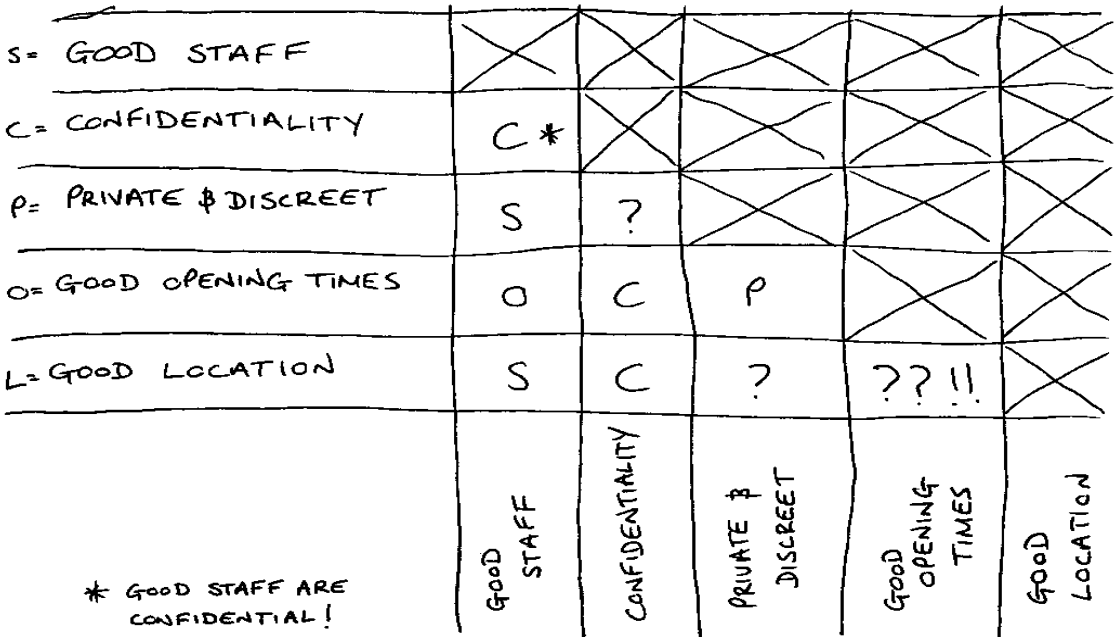

Figure 4. Pairwise ranking of criteria for 'successful' sexual health services

Here, pairwise ranking provided a valuable learning experience for the facilitator who had assumed that barriers would be discrete and have no relation to one another. The fact that the simplistic ranking 'did not work' showed that solutions to single barriers would rarely be sufficient to make a service work well for young people. Instead, the group showed that, when planning and developing sexual health services aimed at young people, all their important criteria need to be given equal consideration.

• Conclusion

Valuable insight into what young people want from different sexual health services, how and when they would use services has been gained from the 'Evaluating Sexual Health Services: a Community Approach' project. Moreover, service providers involved have been enthused by a model that some initially found threatening. Some partnerships between service providers and young people have become solid enough for the provider to explain some of their own constraints to providing a young people friendly service. For example, a GP practice nurse was able to use the evaluation sessions which she had with a group of her young service users to explain that the 'no appointments' or 'drop-in' service could not operate every day. Once the young people realised that this system caused a greatly increased demand on the time of the doctor and nurses, and the subsequent cost implications, they understood why the system only operated on Mondays and Thursdays.

Perhaps the most important lesson learnt during this project with regard to using participatory tools, is not just that they are very powerful, but also that they are very flexible. If they are to be successfully used to enable young people to better understand their situations and plan for change, practitioners should be comfortable enough to use them in a way which is not too rigid or prescriptive. The examples here show the value of this principle, in these different and individual situations.

• **Martin Westerby,** CHDT, Kensington, Chelsea and Westminster Health Authority, 50 Eastbourne Terrace, London, W2 6LX, UK. Tel: +44 (0) 20 7725 3234; Email**:** martin.westerby@ha.kcw-ha.nthames.nhs.uk **and Tilly Sellers,** Technical Adviser: Cambodia, International HIV/AIDS Alliance, c/o Khmer HIV/AIDS NGO Alliance (KHANA), #13 Street 302, P.O.Box 2311, Phnom Penh 3, Cambodia. Email: khana@bigpond.com.kh

19

‘Safely through the night’ A review of behaviour change in the context of HIV/AIDS

Ann Smith and John Howson

• Introduction

‘Safely through the Night’ is a review prepared for the Department for International Development (DFID), UK, by CAFOD[1] and four of its partner organisations in 1998. The review was undertaken to look at:

- communities’ and organisations’[2] understanding of behaviour change in the context of HIV/AIDS; and,
- programme approaches and how/whether these impacted on communities’ behaviour-related concerns.

The title is amended from a Chi Bemba proverb from Zambia, *“Uwankwesha ubushiku, bamutasha nga bwacha”* meaning ‘you only thank the one who guides you safely through the night once it is day time again’. A participant in one of the review workshops cited this proverb to illustrate the difficulties inherent in exploring HIV-related issues within communities. In particular, participatory and experientially based approaches can often raise difficult issues that, at first glance, only seem to complicate matters further. It is only after we have ‘journeyed through the night’, with all its shadows, that we can appreciate the effectiveness of the process.

Four CAFOD partner organisations, Lilongwe Diocesan AIDS Programme, Malawi; Lubancho House, Hwange, Zimbabwe; Mwanza Diocesan AIDS Programme Tanzania and St. Theresa’s Ibenga, Zambia took part in a field-based review with CAFOD staff. Organisations participated in a preparatory workshop where questions for the review were formulated and participatory techniques for exploring these questions were designed and practised. The fieldwork findings were shared at a second workshop and in written reports. Both workshops were facilitated by Francis Chirunga, Intermediate Technology Development Group, Zimbabwe, and Alice Welbourn, Consultant to CAFOD for the review.

The fieldwork was conducted by each organisation among one community where they work and within their own organisation, between March and May 1998. Review participants were divided by age and gender into four groups; Young Women, Young Men, Older Women and Community Leaders (deemed to coincide, in participating communities, with older men). CAFOD staff also conducted parts of the fieldwork with colleagues in London.

Questions covered by the fieldwork concerned:

- the relevance of the organisation’s programme to the community’s main problems;
- how communities perceived the programme’s process of working;

[1] CAFOD, The Catholic Fund for Overseas Development, is the Development Agency of the Catholic Church of England and Wales

[2] CAFOD and its partner organisations

- the outputs/outcomes of the programme's work in these communities; and
- possible future directions for the community and the programme.

The questions were intentionally constructed so as to be broader than the specific objectives of the review. In this way it was hoped that any reflections on behaviour change would emerge from communities' lived reality rather than as a response that could have been skewed had the review taken a more direct approach focusing specifically on HIV-related behaviour change.

• Field work methodology and main findings

Relevance

Participating communities and organisations considered the main problems facing their community and how/whether these are being met by the organisation's programme or by others. Sunburst diagrams, pairwise ranking and bar charts were used to identify the main problems and support received. The sunburst diagram produced by young women from Malawi illustrates some of the problems identified by communities (see Figure 1). Collating the findings into an issues matrix indicated the problems identified by each and the differences that can occur between communities' and organisations' perceptions, as seen in Table 1.

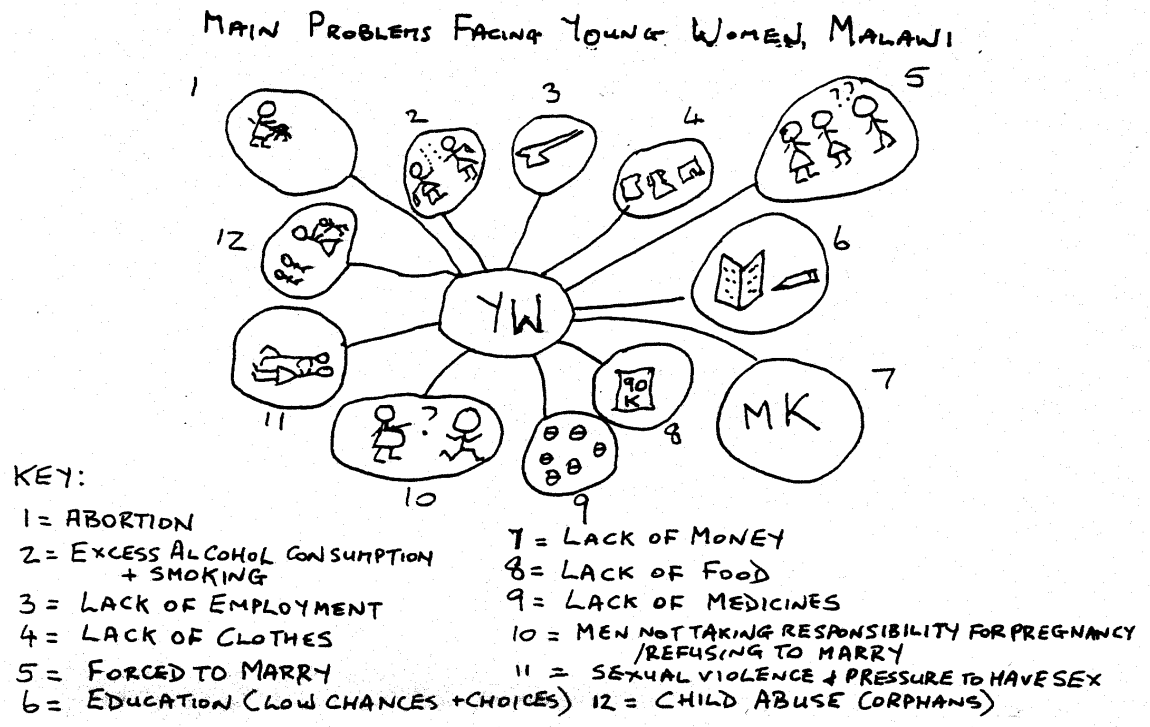

Figure 1. Sunburst diagram showing main problems facing young women respondents, Malawi

Table 1. The main problems faced and the extent to which felt needs are being met, Malawi

	YW	YM	Org
Lack of employment	✓ x	✓ x	
Sexual violence and pressure to have sex	✓ x	✓ x	
Lack of counselling and advice from parents	✓	✓ x	✓
Excessive drinking and smoking/drugs	✓	✓ x	
Transport			✓ x
Inequality oppression from dominant young men success is based on privilege and connection rather than on merit		✓ x	
Men are not taking responsibility for pregnancies/refusing to marry	✓	✓	
Need of money	✓ x		✓ x
Young girls have less opportunity/access to education due to cultural expectations and burden of domestic chores	✓ x		
Lack/shortage of HIV/AIDS and 'Why Wait?' education materials			✓ x
Condoms not the solution			✓
Condoms – we need them		✓	

Key
The ✓ indicates that this problem was drawn on the bar chart as a main concern of the peer group. The x beside it indicates that the peer group felt this concern was getting less than 40% support from any or all different sources.
YW = Young Women. YM = Young Men

Despite the high HIV prevalence in all fieldwork locations, communities did not identify this as a main problem. The Zimbabwe team reported that one meeting started several hours late because community members were trying to get rid of elephants that were damaging their crops. The chief's comments were instructive; *"You come to us with your AIDS programme while we have a bigger problem of elephants destroying our fields. Why don't you ask the national parks to kill the elephants?"*

Process

Using sunburst diagrams and *sadsa* or pie charts, participants reflected on how they perceived the activities of the programme and which they considered most important. Time lines illustrated who within their community got involved, when and why.

Young men and young women were concerned about sexual health issues. Both groups were also anxious to access education and skills-building programmes, young men for reasons of self-esteem, young women for financial independence. Only women (young and old) were involved in home care and orphan care programmes, illustrating the potential danger of these adding further to women's already heavy burden of care (and of excluding men where programmes focused solely on care initiatives). Older men (community leaders) subscribed only to activities that increased their political standing within the community. There was no acknowledgement of the relevance of HIV/AIDS to their personal behaviour. AIDS education was scored highly by young people of both sexes but not by older people, raising the question as to whether the old were being overlooked. Behaviour change activities also concentrated on youth groups

and left out older people who are the decision-makers over the young.

In their gender- and age- specific groups participants used seasonal calendars to identify:

- the volume and types of work undertaken by each in the different seasons;
- times of financial solvency and periods of heavy expenditure;
- occasions of community festivities/peak social events; and,
- their feelings of contentment or unhappiness plus tension points in different seasons

The calendars identified the differing workloads of women and men. They indicated the best and worst periods for programme activities with each group and also how sexual activity/vulnerability varied according to season (and times of community festivities) and according to the amount of free time and funds available, and therefore how programmes should target their activities accordingly.

Seasonal calendars (see Figure 2) also illustrated the domestic tensions caused by alcohol consumption, quarrels over finances and, most often, quarrels over sex (demanded by men and refused by exhausted women). The older women's group from Zambia told how in many instances, when they are tired and refuse sex, their husbands make them sleep under the bed. Sexual violence, highlighted as a problem only by women (older and younger) was not considered thus by men. Physical violence also featured, identified as a grievance by women and a right by men. Younger men from Zimbabwe affirmed their rights to beat their wives if they found them sleeping, exhausted, in the fields.

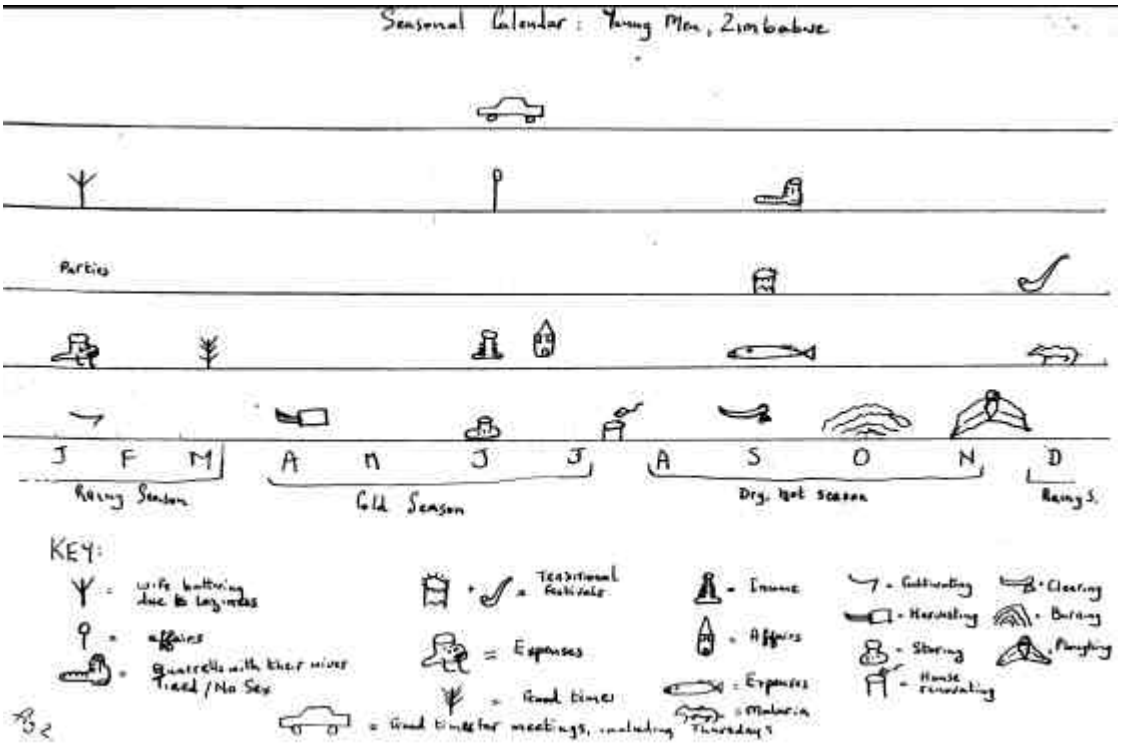

Figure 2. Seasonal calendar: Young Men, Zimbabwe

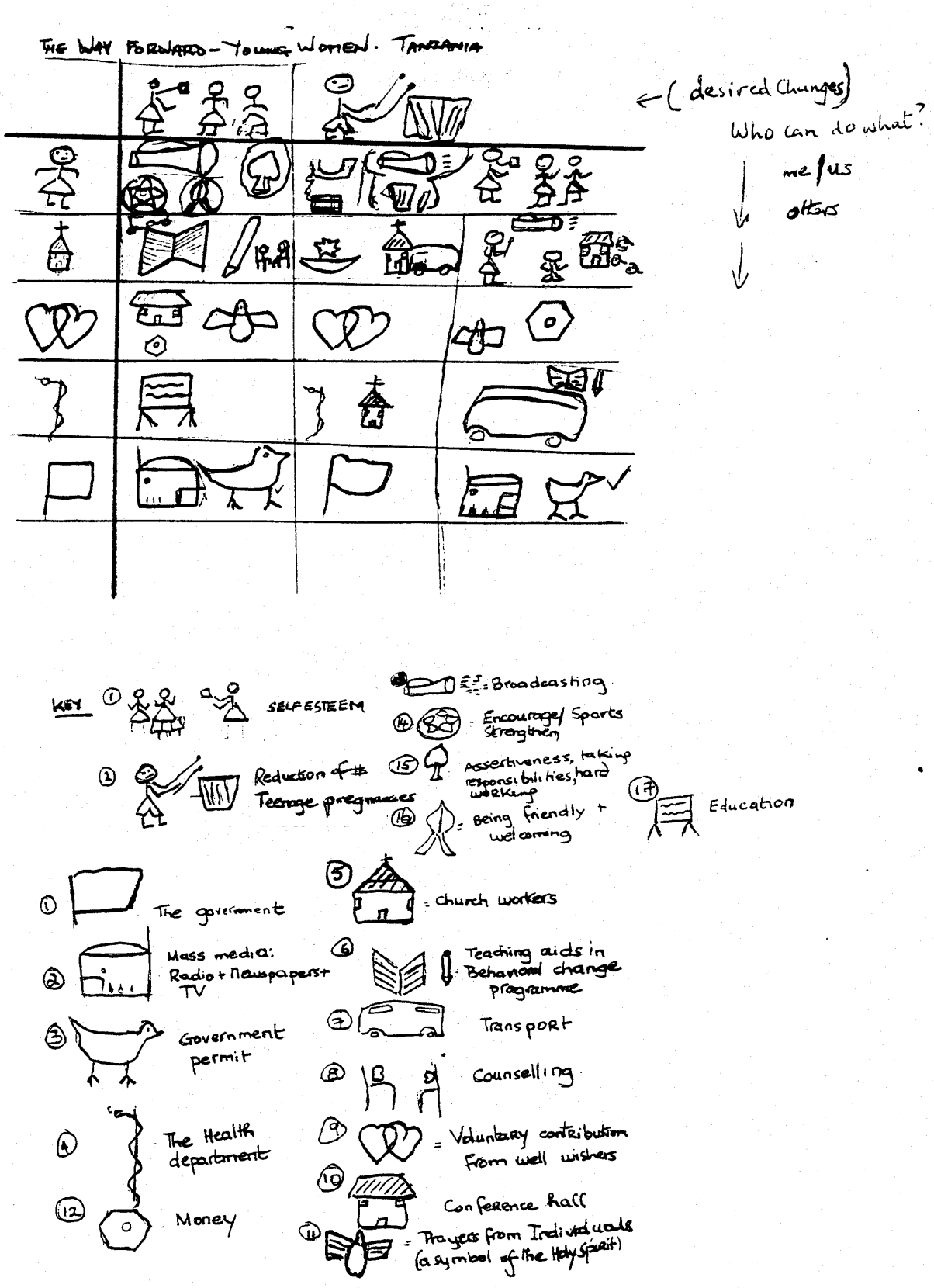

Figure 3. The way forward. Young Women. Tanzania

Outputs and outcomes

Using split sunburst diagrams and freeze work (also known as frozen role-plays or tableaux), communities identified positive and negative behaviour changes attributable to programme activities. Communities perceived behaviour change to concern more than personal sexual behaviour. It was also to do with achieving reduced stigma and discrimination against those infected/affected by HIV/AIDS and an increased willingness to acknowledge and care for people with, and children orphaned by, AIDS. Change was also evident through an increased sharing e.g. couples sharing information on sexual matters and fathers more able to talk about sex with their children. People also discovered how they misinterpreted each other's expectations. For example, in Zambia, married women said that men imposed dry sex on them whereas the men said it was the women who wanted it. When the two groups got together they realised that this practice was something inherited from the elders. The men are willing to have wet sex now.

Negative changes identified included, in some instances, greater dependence on service providers with people less likely to provide care themselves, greater distrust between young men and young women, heightened fear resulting from increased knowledge of HIV/AIDS and parents suspicious of programme activities with young people (because they were left out of the planning). Through freeze work communities also identified how they might strengthen the positive changes and minimise the negative aspects for the future.

The way forward

Community participants used a 'significant changes' diagram to identify priority changes for the future (see Figure 3). The illustration for young women in Tanzania shows the desired changes in the top row. In the row immediately beneath they identify what they themselves can do to achieve this. Subsequent rows identify what someone else can do to make this happen.

• Lessons learnt and recommendations

1. Participants' understanding of behaviour change in the context of HIV/AIDS

- HIV-related behaviour change is not just a matter of personal sexual behaviour. It is also concerned with reducing discrimination against and providing support for those infected or affected by HIV/AIDS.
- Changes in personal sexual behaviour are inextricably linked to an increased level of caring, sharing and learning among individuals and within a community.
- Personal behaviour patterns are not a matter of autonomous individual choice but are determined by a host of social, cultural, economic and gender-related factors and by major seasonal influences.

2. Programme approaches more likely to impact on communities' behaviour-related issues

- Communities' felt needs must be the starting point of any work. Behaviour change and HIV-related programmes will only be effective in as much as they are also concerned with communities' 'elephant problems'.
- Programmes must ensure all sectors of communities are active players at every stage, thus strengthening their sense of ownership and relevance and minimising risks of dependency. Equally, people with HIV or AIDS must also be active players, as appropriate, in planning and implementing programmes and in decision-making processes.
- Programmes need to take a holistic approach to addressing the complexity of traditional, cultural, economic and legal issues affecting behaviour. A narrow focus on HIV education and provision of care is unlikely to impact on behaviour longer term. Also, while Information, Education and Communication (IEC) activities are important in providing a basic understanding of HIV and its prevention, IEC alone is rarely effective in producing sustained behaviour change.
- HIV programmes must be set in the context of wider sexual health, teenage

pregnancies, Sexually Transmitted Infections (STI), infertility, sexual violence and other problems that are an integral part of people's lives.

- Any work on behaviour change needs to examine the roles of women and men, the relationships between them and the factors that determine the power/powerlessness of each.
- The review highlighted the connections between widespread gender-based domestic violence, (including sexual violence, physical violence and psychological abuse), and vulnerability to HIV and the need for programmes to address this as a central part of their work.
- It is essential to define what agenda or philosophy is informing programmes addressing behaviour change and whether this is congruent with the above points.
- Communities cannot be regarded as a single homogenous mass. No single set of authority figures can be considered to represent the situations of all community members. Similarly, no one programme activity will engage all community members or respond to their needs. The review stressed the importance of working with separate peer groups, based on gender and age, and perhaps on other locally relevant criteria such as HIV status, socio-economic well-being, religious affiliation etc. Integral to such a process is the step of also bringing the peer groups together regularly to enable intra-communal learning and sharing. Otherwise the result may be increased suspicion and misunderstanding between the groups.
- Programmes need to recognise the influence of the 'seasonality factor' on behaviour, to identify the specific seasonal commitments and pressures affecting the different peer groups and respond accordingly.

• Comments on the participatory process

The participatory nature of the review brought out considerations that were totally unanticipated by programme staff. Similarly the different age and gender groups discovered aspects of each others' concerns unknown until then and which may never have emerged in mixed groups or through less participatory processes.

Communities found the participatory process empowering. They welcomed the experience of actively contributing to the review and feeling a distinct sense of ownership for future directions of their programme.

The process was also empowering for programme staff. It identified community concerns not uncovered in a more 'top down' approach. It also identified organisational difficulties or shortfalls, some of which were being addressed immediately. The review highlighted organisational and political problems that adversely affected the Malawi programme and made it impossible for its staff to complete the review with all sectors of the selected community. This programme has since undertaken a major evaluation prompted largely by the experience of this participatory review. In Zimbabwe, the education department revised its mode of programming as a result of the benefits highlighted by a participatory process and the recommendations that emerged. In Zambia the programme immediately set about decentralising its service from the immediate catchment area of the hospital base and establishing a wider network of teams servicing further-lying rural areas. The Tanzanian participants report that work undertaken with other programmes in their support network is increasingly adopting a participatory approach. Within CAFOD, the HIV-related training and programme support work draws more firmly on participatory processes and takes the programme-related recommendations of the review as its yardstick for appraising funding proposals and reflecting with partner organisations on issues regarding behaviour change.

By looking at communities' general concerns the process avoided a narrow focus on behaviour change divorced from wider issues and influences. At the same time it afforded an opportunity to explore the impact on behaviour of these wider issues. It also allowed organisations to review the relevance of their programmes to communities' identified concerns.

Although participatory processes are widely used in community-based development work, they have only slowly been applied to HIV-related issues. Perhaps the very fact that HIV/AIDS is a taboo subject in all our cultures or that it inevitably touches on intimate issues of personal and community behaviour, has discouraged development workers experienced in participatory research techniques from applying these approaches to HIV/AIDS. Yet the group-specific, experientially-based and informal nature of this review enabled a degree of unbiased sharing on sensitive issues that might not have occurred with a more academically rigorous 'top-down' approach. Experiences described here, along with publications such as Stepping Stones[3] and Confronting AIDS Together[4], illustrate how participatory processes are eminently well suited to communities' exploration of HIV-related behaviour issues and demonstrate the advantages of participatory research techniques in drawing on people's lived experience to examine sensitive issues.

- **Ann Smith** and **John Howson,** CAFOD, Romero Close, Stockwell Road, London, SW9 9TY, UK. Tel: +44 020 7733 7900; Fax: +44 (0)20 7274 9630; Email: hqcafod@cafod.org.uk; Website: www.cafod.org.uk

ACKNOWLEDGEMENTS

The work described here is the fruit of contributions from individuals and communities, who, in all respects, are co-authors of this article. We gratefully acknowledge the generous co-operation of the following individuals and organisations:
The Community members of Lilongwe, Malawi, Ibenga, Zambia, Mwanza, Tanzania and Hwange Zimbabwe, and the staff at CAFOD who participated in the fieldwork. Maggie Mshanga and Ernesto Makoka, Lilongwe Diocesan AIDS Programme, Josephine Komba Mdetele, Mwanza Diocesan AIDS Programme and George Kanga, National AIDS Co-ordinator, Tanzanian Episcopal Conference, Lillian Kazembe and Chanda Fikansa, St. Theresa's Hospital, Ibenga, Lillian Ishemunyoro, Thomas Chinembiri and Nelson Mapako, Lubancho House, Hwange all of whom facilitated the fieldwork and participated in the related workshops. We also thank the Directors and other Staff and volunteers of these organisations; Francis Chikwanda Chirunga Zimbabwe, Workshops Co-Facilitator and Alice Welbourn, England, Workshops Facilitator and Review Consultant to CAFOD.
Staff of CAFOD's International Division who collaborated in planning the review and preparing the report for DFID.

[3] Stepping Stones; A training package on HIV/AIDS, gender, communication and relationship skills. (Part of Strategies for Hope Series). Welbourn, Alice. ActionAid, London, England, 1995

[4] Confronting AIDS Together. Skjelmerud, Anne & Tusibira, Christopher. DIS/Centre for Partnership in Development, Oslo, Norway, 1997

20

Learning to relearn givens

Jill Lewis

• The project

Living for Tomorrow is a three-year action/research pilot project at The Nordic Institute for Women's Studies and Gender Research (NIKK). It is working for HIV prevention with a key focus on gender issues affecting sexual beliefs and behaviour. It is actively engaged with people from countries belonging to the former Soviet Union, with its core action collaboration in Estonia, an active 'satellite' link to Lithuania and involvement from St. Petersburg in Russia.

The main efforts of the project are:

- to develop ways of working on sexual risk information and behaviour that radically centre the questioning of gender norms and traditions;
- to help people learn to use inter-active/participatory learning methods;
- to mobilise involvement of young people in HIV prevention, since it is the agency of young people themselves that will most effectively stem the epidemic;
- to develop commitment to inclusion and collaboration across differences: whether those be ethnic, national, religious, age, educational or sexual; and,
- to link research on gender and educational strategy to actual HIV prevention education

• Focus on gender

The project approaches HIV by exploring how gendered sexual behaviour, shaped by cultural and social norms, lean people towards risk sexual behaviour. The 'Living for Tomorrow' project argues that beliefs about how men and women 'are assumed to be 'naturally'' or are expected to behave 'as men or as women' form a very important part of what normalises unsafe sexual behaviour that spreads Sexually Transmitted Diseases (STDs) and HIV. Gender is seen as a social and cultural system that has institutionalised problematic inequality between men and women. If the dominant gender system in a culture normalises forms of passivity, complicity, dependence or disempowerment for women, and normalises forms of control, exploitation, access to power or force for men, that very gender system itself needs to be changed in order to support safer behaviour that depends on more democratic sexual relations. Drawing on recent gender and feminist research, and the most challenging of international debates on gender and AIDS, the project explores how a gender-focused approach could work for people in contexts where the discussions of 'gender' have not had wide circulation.

The participatory work aimed to allow participants to explore assumptions that shape masculinity and femininity in their daily lives. The work needed to be constructed in ways that made sense to people locally. The vision also was to root the initiative in Estonian contexts, develop local involvement, resource it with international data, analysis and debate and provide capacity building. From this we hoped to develop a 'core group' who would then continue to design and run workshops with young people to initiate mini-projects on the gender and sexuality theme with them. The project would document its vision, gender focus, methods and the implementation issues it faced to enable possibilities of transferability to other parts of the region, and to encourage stronger gender focus in sexual health education.

Setting things in motion

Core collaboration was established with The AIDS Prevention Centre, Tallinn (the capital

of Estonia) and its director, Nelli Kalikova. Preliminary meetings with people engaged in different dimensions of Women's Studies/Gender Research and sex education in Estonia helped identify how people understood and talked about gender and how the post-Soviet and new national independence contexts influenced the ways people thought about men and women. They began to establish a web of possible links between new Gender Studies work in Estonia, ongoing Nordic and international gender research, international data and debates on HIV prevention/education methods, and the people actually engaged in sex education/HIV prevention initiatives.

Stephen Clift[1] became consultant to the project. It was important for the gender-focused work to centre collaboration of a man and a woman in the active implementation of the work with participants. Women are often over-represented in sex education. To tackle the issues at stake in the spread of HIV, men's active participation is needed.

Recruitment of participants for the core group was slightly nerve-wracking. We needed people who showed signs of curiosity and excitement at exploring and creating new approaches, not people who constituted themselves as knowing experts and authorities on HIV. Also financial difficulties, poverty, low wages and limited possibilities in transitional Estonia, meant that it was complex, yet crucial, to find people really interested in working on *this* project, and not just on *any* project where there might be Western funding and links with the West. We also wanted people from diverse backgrounds, to create possibilities for new exchanges. 31 people joined the Capacity Building workshop, from which we would draw the core group; most from Estonia, 4 from Lithuania and 2 from St. Petersburg. Participants ranged from Women's Studies/social work/psychology students, AIDS Centre workers, teachers, gender studies researchers or lecturers, people whose lives were directly affected by HIV, people with medical backgrounds, youth workers etc.. The attempt was made to include men (though not as many as hoped for) and to have a diversity of people from both Russian and Estonian backgrounds, reflecting the population profile of Estonia today. Five or six people would then be needed from the Capacity Building group to commit themselves to take the project into its next stage of work with teenagers.

[1] Centre for Health Education and Research at Christ Church University College, Canterbury, England.

Capacity building

Capacity building work aimed to open up what we called 'critical literacy' about gender issues, in dialogue with sexual health/safety concerns and information about HIV and AIDS.

The concept 'gender' was new for most participants. In Estonia 'emancipation of women' or 'equality for men and women' have echoes in ideological impositions of a totalitarian Soviet past, a Soviet-stereotyped Western feminist hysteria or uninteresting Nordic neutering. Participatory processes are very foreign in post-Soviet contexts, where education had been disciplined and hierarchical, delivering expert knowledge to compliant students. An Estonian saying is that 'children may talk when chickens pee' (which means never). We hoped participants could experience the *feelings* of interactive learning and the energy it releases. Stephen and I also wanted to make evident the *processes* of running the capacity building, and model flexible collaboration involving good listening and support, criticism and humour.

The capacity building sessions ran over 6 days over 2 weekend workshops. We made a particular effort to link the 'importing' of the gender focus, unfamiliar to most Estonians, to real issues and conditions in daily life in Estonia; to find ways to let people themselves identify and discuss gender-related issues. We juxtaposed open-ended, interactive sessions, with input from Estonian research and international discussions, shifting methods and reflecting on how sessions were structured as we went along. We wanted people to access gender issues and interactive learning methods by experiencing them for themselves in the workshop, and to begin to reflect critically on the implications of these identified experiences. We also wanted people to be challenged and energised and for some of

them to be inspired to work further with the project. Each individual session had specific written evaluation feedback, and longer evaluation comments were sought at the end. Each day was organised under a thematic heading (see Table 1).

Table 1. Organisation of the workshops

Weekend Workshop 1	
Day 1: Setting the stage for collaborative work	• Welcome by Nordic Information Office, Tallinn • Ice breakers. Introductions: facilitators & participants • HIV/AIDS situation in Estonia & regionally • Project concerns, aims & possibilities • Where are we starting from? (1) • Taking stock of what is known (2) • The gendered scenario of sexual risk (3)
Day 2: So what's all this about gender?	• Why gender matters (4) • Current imaging of gender in Estonia (5) • Gender issues in Estonia today (6) • Gender assumptions in Estonian media (7) • Stories young people see (8)
Day 3: Where gender really matters: men, women, bodies, beliefs and behaviours	• The Male in Our Heads? (9) • So what happens ? What people say and tell.(10) • The gendering of sexual behaviour (11)
Weekend Workshop 2	
Day 4: Not just words and ideas: but a gendered, embodied self	• Reconnections & feedback from week • Working with young people: interactive strategies (12) • Embodiments of gender I (drama methods) (13) • Making a difference: what is known about changing behaviour (14) • Life in Estonia with HIV and AIDS (15)
Day 5: ' Doing IT': young people and sex	• From theory into practice: taking sex seriously (participatory method sample activities) (16) • Lessons learned (17) • Embodiments of gender II: loosening the borders from inside out (drama methods) (18) • Gendered sex and young people (19) • Embodiments of gender III: staging power (drama methods) (20)
Day 6: So where do we go from here?	Action agenda for Living for Tomorrow 1999: next stages of the project, processes of co-ordination; resourcing ideas; practical signposts -where to go next Concrete plans Winding up, taking stock: concerns, reflections, what people are taking away, and commitment to ongoing work Evaluation time Saying farewell

• The first workshop weekend

The opening welcome set the initiative within Nordic governmental priorities. The session on HIV/AIDS by the director of the Tallinn AIDS Prevention Centre anchored the project within national concerns with local support. The first workshop was on feedback collected in advance from participants about differences in problems and expectations young men and women face in Estonia today. This brought personal visions of gender into discussion, through small group debate and larger group discussions. It began reflection on the wider social and sexual implications that the problems identified raised (e.g. men and risk taking; women and fear).

The next workshop was based on findings by Estonian researchers about sexual knowledge and behaviour of Estonian youth (2). Instead of presenting the findings, we designed a questionnaire asking people, in pairs, to think what findings they would expect concerning boys and girls. These were then discussed in a group of everyone together in relation to the actual findings of the research where the discrepancies between participants' expectations and the findings were considered. Finally we watched an explicit but careful Danish sex education video made for young people, some key extracts from the film 'Kids[2]' (3) and discussed informally 'cultural framings' (i.e. images of sexual behaviour that circulate through education and the media) of images of sexual behaviour and information.

The next day began by placing concerns of the project within international research and debate on sexual health and the AIDS epidemic (4). Then a 'doing' workshop session followed which was based on magazines and newspapers obtained from that morning's newspaper kiosks (5). In small groups, participants took this material, which included subjects ranging from sports, porn, food and teenage magazines to home decoration etc., from Estonia, Russia and other countries, and made separate collages of images of men and images of women. These were then mounted on a wall for 'men' and one for 'women' and participants guided a partner round the images, explaining to them what a man is and what a woman is, based *only* on the images. A huge amount of humour and argument and surprise was generated from this.

Two 'formal' presentations from Estonian Women's/Gender Studies lecturers, followed. It was important, given the general unfamiliarity, and indeed, some scepticism, concerning the use of participatory practices, to include formal, more familiar formats as well. This generated discussion of different responses and receptiveness to these sessions in contrast to other interactive ones. The talks highlighted how differences between men and women are historical, social and political. The first brought into discussion recent findings on how the situation was changing since the collapse of the Soviet Union (6). A general belief that 'men and women are equal in Estonia' co-existing with the sentiment 'we are now free not to be the distorted 'working' women of soviet ideology, but real, free, feminine women' was set alongside new data on the impoverishment of women, lower pay, the increased tensions in domestic life and generated very intense discussions of information and personal experience.

A talk by an Estonian journalist/researcher analysed how women are represented in 'political' coverage in a popular Estonian newspaper (7): how men's authority and influence is stabilised in how their activities are reported, while women in politics are trivialised. An evening session (8) showed the video *Dreamworlds II* which critically examines how sexuality is exploited in MTV rock videos to normalise men's and women's sexuality within certain assumptions of violence and abuse. The discussion and beers, with people, all sitting round on the floor in a close cluster, lasted long into the evening. The shift from Soviet censorship to free-flow Western media and its commercial usage of sexuality was discussed in relation to youth culture and sex in Estonia today.

A workshop session, inspired by findings of the Women Risk AIDS Project research (9), had small groups agreeing or disagreeing

[2] *Kids* is powerful film from the US, filmed from the perspective of inner city teenagers, which focuses on the type of boy-girl behaviour that leads to the spread of HIV.

about women's and men's sexual behaviours. Statements had to be allocated to true, false or unsure categories, such as:

- 'Women's priorities in sex are to please men';
- 'Women have difficulty telling men about their sexual desires' etc.

Participants circulated amongst the groups in order to see how groups had allocated the statements, and people explained why and how they had taken decisions, and also, where disagreements lay. Huge discussion was generated by this, both between and within men and women. A relaxed meeting, with very active discussion followed with an Estonian director who had produced a play from 'sexual biographies' collected by researchers in Estonia and taken the production into discussion with audiences (10). Gender issues were featuring more and more in the participants' discussion. A lecture, and question/answer/comment session ended the first 3-day session (11). It brought into critical focus the gendered sexuality issues that sexual health interventions need to address, incorporating issues raised during the first 3 days.

People were asked to keep notes and cuttings about conversations or issues observed during the process that related to our discussions and bring them to the following weekend session. Care was taken in the warm-up and 'saying goodbye' processes to strengthen connections within the group.

• The second workshop

A week later, after starting proceedings with group activities to set adrenaline going again, and reporting back on the week's observations, we set up activities modelled on participatory learning work from Health Wise[3]. We used 'problem letters' written to a youth publication by young people in Estonia to set up a concentric circle carousel, where participants seated in the inner ring presented problems to those rotating in the outer circle and listened to their 'constructive advice' (12) concerning how to resolve the issues identified in the problem letters. Then there was discussion about the diversity of available advice, the complexity of dealing with specific problems in specific lives and the difficulties faced in communicating effectively.

There were three drama workshops focused on gender and sexuality run by two actors from the Split Britches Company[4] (13, 18, and 20). Their own productions focus with humour, critical insight and generosity on the tensions of masculinity and femininity. They drew on forum theatre methods, and got participants moving, miming, acting embodiments of noises and power, gesturing large and small, throwing imaginary body parts into the circle etc. People in pairs made safer sex slogans and produced, with their bodies, an image for them, which was photographed with an instant camera and mounted onto a wall display. Objects from pockets formed a basis for recounting half-memory/half fiction stories of love, sex or romance, told in the first person, then passed on and retold in conjunction with the object. The circulated, altered stories were told to the full group, who then picked ones where gender and power were at stake and staged the story with members of the group. The final act was to change the body language of one person in the story to see what different story could then be read from its embodiment.

We discussed how research on sex education shows only limited behaviour change, when people are just told what to do. We considered how evaluation and research could help inform more effective engagement with young people's awareness and behaviour change and how actual education is crucial (14). Evenings of informal discussion with people living with HIV and AIDS provided the participants more private time spent in small groups with no large group feedback (15).

We sampled ways of conducting gender-focused warm-up/icebreaker exercises (16), and circulated examples of exercises that could be adapted for workshops. We discussed preparing and facilitating participatory methods in the next workshop, telling people

[3] Cohen, J. and Wilson, P. *Taking sex seriously: practical sex education activities for young people*, Health Wise, Mersey Regional Health Authority, Liverpool, UK.

[4] A feminist theatre company whose performances challenge gender norms and which teaches about drama and gender

how we prepared sessions and how we processed what has happened together, providing critical feedback, identify what the theories behind the practice were etc.(17). People reflected on their own responses to the experiences of the participatory workshops. They discussed their feelings of ambivalence, their feelings of being 'enabled' and empowered, as well as their moments of resistance at certain points during the workshop sessions, in the context of their other 'non-participatory' educational experiences.

The final day focused, by way of small group discussions, on taking forward an action agenda for the project, looking at what the next stages might look like. 11 people volunteered to join the 'Core Group' that would be central in carrying the project forward in Tallinn.

Next steps

Following the capacity building, the Core Group met regularly, independently and through e-mail dialogue with NIKK project co-ordinator and designed and organised eight days of workshops, held at weekends over 2 months at the National Library, for a group of 25 Estonian and Russian 15-16 year olds. The teenagers, recruited from Estonian and Russian schools in Tallinn, were contracted into the project, and were given certificates recording their participation. All parents were informed about the project and were given opportunities to learn more about its work. The Ministry of Education and School Principals gave support for time off from school for some of the youth workshops. Some young people conducted video-interviewing projects on attitudes to sex and gender; some of them are now finalising a 84 page booklet called 'How To Bridge The Gaps Between Us?' on gender and sexual relations and safer sex, including a ten page 'vocabulary' in Estonian, Russian and English, of words relating to sex and gender. In August 1999, the majority of the Core Group established themselves as an NGO and drew up 3-year action plans in order to take their work further across Estonia, for which they are now trying to seek funding. Activities to date have included presentations at various national and international fora and dissemination of materials through articles and on the world wide web.

• Conclusion

HIV and AIDS is partly an epidemic of poverty and social vulnerability, where resources for education and health are too limited, where despair about changes and survival permeates peoples lives, but it is also an epidemic moving along very nerves of life and diverse interpersonal relationships in negative ways. The focus on critical literacy about gender and power in people's lives and the often problematic terms of men and women's sexual relations, along with the engagement with collaborative learning and education processes, appears to have opened up an interest and energy in people to acknowledge the problems and become an active part of creating some part of the solution. There is now an urgent need for the multiplication of energies to engage in the participatory and gender-focused work of more effective prevention processes, in every country in the world, in the face of the relentless spread of HIV and its dire human consequences.

• **Jill Lewis (**Living for Tomorrow NIKK), Nordic Institute for Women's Studies and Gender Research (NIKK), P.O. Box 1156 Blindern, 0317 Oslo, NORWAY. Tel: + 47 22 85 89 31; Fax: + 47 22 85 89 50; e-mail: jill.lewis@nikk.uio.no Website: www.nikk.uio.no

NOTES

For further information about the project see: www.nikk.uio.no/Instituttet/Verksamhet/LfT/LfTE.html

21

Putting breast cancer on the map

Helen Lynn, Diana Ward, Cathy Nugent, Laura Potts, Liz Skan and Nicola Conway

• Background

'Putting Breast Cancer on the Map' grew out of the work the Women's Environmental Network (WEN) has done on polluting chemicals in the UK over the last ten years. The project developed out of a need identified by women to participate in positive action to bring about change in the minds of the government and medical establishments, as well as society at large, about the way in which breast cancer is viewed, treated and politicised in the UK.

The primary basis for this research has been the rising incidence of breast cancer in the UK, where the estimated lifetime risk for all women is now 1 in 11. Levels of incidence have increased every year this century[1]. The disease was comparatively rare 200 years ago but today it is the commonest cause of female cancer death and the top overall cause of death for women aged under 50[2]. In world terms, breast cancer incidence has increased by 33% between 1987 and 1997 (Lancet 1997). But of equal significance in terms of the design and focus of this research is the growing concern that the contributing cause of the disease may lie in the state of the physical environment we inhabit (Read 1995; Steingraber 1997).

Research carried out in Israel (Westin and Richter 1990) and studies of Long Island, USA (cited in Read, 1995; Steingraber 1998), Cape Cod, USA (Silent Spring Institute) and Lincolnshire, UK (Watterson 1998; Rattanamongkolgul et al., 1998; Dispatch 1994) have highlighted the necessity to consider the state of our lived environment to be a significant risk factor for breast cancer. Research into genetic and heritable determinants of breast cancer has proliferated since the discovery of the marker genes BRCA1 and BRCA2[3] in 1994, despite the fact that inherited breast cancer accounts for only 8-10% of all cases (Kelsey and Bernstein 1996).

In 1995 WEN submitted a petition called the National Action Plan for Breast Cancer to the Department of Health. The 80,000 signatures on the petition highlighted the need for better care and treatment of women with breast cancer. The petition particularly called for more emphasis on prevention to stop the epidemic of breast cancer for present and future generations. Petitions are an intrinsic part of campaigning and a useful tool in terms of developing networks, raising awareness and getting the issue 'out there'. However during the lifetime of the petition, it became clear that there was a distinct lack of places to refer women to when they contacted WEN with concerns about possible links between breast cancer and their environment. Women wanted to do more to publicise the breast cancer issue than sign their name to a piece of paper. They wanted to be active in campaigning at both a local and a national level to raise awareness about breast cancer and the urgent need for prevention. This need for participation developed into the project network that we continue to play a part in to this day.

WEN identified the need for a focal point for reporting and collecting women's concerns about their health and environment. A project was devised around a means of collecting this

[1] Breast Cancer Campaign (BCC) 1997; Cancer Research Campaign, (CRC) 6.2, 1996; Zeneca 1998.
[2] BCC 1997. CRC, 1997, 1996.

[3] BRCA1/BRCA2 are human mutated genes that indicate a predisposition to breast cancer, with a 75-85% lifetime risk for people carrying these genes to develop the disease.

information via a questionnaire and a map drawing exercise. Project workshops were organised to facilitate the mapping process and as a method of engaging and supporting women to express these concerns about breast cancer and the environment in a group setting. In 1997 we submitted a successful bid to the National Lottery Charities Board who granted us £135,000 for a two-year project.

• Project design

The project focused on new ways of collecting information in a participatory, non-threatening and empowering way, using the network that had already begun to form. Traditional epidemiological methods of research do not usually involve the individuals or communities affected by a particular pollution source other than as study subjects and are characterised by a top-down approach. This effectively excludes local communities from participating in processes by which knowledge about health and the environment is collected. Involvement in policy or decisions reached and input into plans for change or improvement is therefore limited. There is little or no room for personal experience and concerns to be voiced by community members. A different method of collecting information was needed in order to involve women and their communities directly in the study by asking them to be their own experts. We contacted women's studies programmes for information on women's research methods. This proved useful in terms of reaffirming the value of qualitative research methods as a means of collecting women's perceptions. One of the most useful packs of information utilised was one on Participatory Appraisal from the Institute of Development Studies (IDS) at the University of Sussex. It illustrates how participatory mapping methods have been used to explore issues as diverse as women's time usage, land usage, sexual health and body image.

The project asked participants to be the researchers, as they already possessed all the skills, knowledge, experience, enthusiasm and local knowledge necessary to compile maps. They also had a vested interest in themselves, their communities and their environments to do this and this was what was missing with traditional methods of research. As one woman wrote:

"I am very concerned that breast cancer seems to be quite prevalent where I live but I can't really say or put my finger on any one thing, there seems to be so many and it becomes bewildering at times".

By involving women actively in the research process, the project sought to build on women's concerns and reach out to women all over the country to make the kinds of connections that might help identify avenues for change.

Mapping

The idea of drawing maps came from the women who were involved in collecting signatures for the petition. They were concerned about high incidence of breast cancer and what they perceived as 'clusters' either in their work or living environment. Although a number of academic and independent studies have investigated certain identified clusters, few definitive answers have been found. The definition of a cluster, as stated by the National Cancer Institute, is the occurrence of a greater than expected number of cases of a particular disease within a group of people, a geographic area, or a period of time.

Yet most clusters are initially identified by concerned residents who may live in what they define as a high incidence area or cluster. When investigated however invariably their concerns are dismissed but they are still left to worry that certain elements of their environment were overlooked. For example in the West Midlands, research around a particular landfill yielded no significant increase in ill health or breast cancer incidence. The local women knew this was because the area under study was governed by two different health authorities so the 'cluster' became half its actually size under each authority.

Maps have been used throughout history as a means of giving visual representation when discussing issues of importance, giving directions and locating landmarks. They are a very easy way of conveying information about how we relate to our environment and people tend to relate to them more easily than the

spoken word. Anyone can draw a map, you do not have to be literate or even speak a common language. They are also a good and safe way for people to convey different aspects of their lives that they may not readily admit to in words.

The background research began by looking for other examples of maps drawn by other individuals and communities. There were some very good examples of Parish maps from organisations such as Common Ground[4] and examples from America where people were reclaiming maps as a means of identifying their bio-regions. There was also some interesting work being undertaken by some trade unions and labour activists looking at risk mapping of work environments as a useful means of indicating health risks in the work place. However these offered very little guidance in terms of women mapping health effects.

Compiling maps seemed to be an ideal way of collecting information that reflected past and present experiences of possible environmental pollution. The idea of map drawing was difficult to get across to participants in theory which made the workshops an intrinsic and crucial part of the project. The idea was that maps needed to come from the participants themselves and they needed to be individual. Purposefully no specific example was given in the project information pack as it was felt that participants might 'copy' the example and so the ideas would not come from them but be dictated by WEN. Maps were a way in which women could identify these 'clusters' while maintaining confidentiality about themselves and other individuals locally. They also served as a way for women to recall things that had happened in the past and think through possible connections, as the following comments show:

"The mapping exercise was quite useful because it made me think of incidents nearby that had happened in the past. "

"With hindsight I remember 42 years ago complaining of the smell of ICI[5] when I lived at Norton on Tees (near Stockport). Air pollution was appalling in Billingham where my husband worked. My next four children were born, 2 months, 1 month, 6 weeks and 1 month premature - I developed breast cancer 31 years ago".

"When we first moved to the countryside I used to lose my voice when they sprayed the crops. All the family suffered from a feeling of grittiness in the eyes, some light headedness, headaches, tightness in the chest etc., when crops were sprayed".

Questionnaire

It was not enough to get visual representation from individuals about their experience. We needed to collect more personal written information in a questionnaire format. The project design was therefore two pronged with the more visual representation on the maps being submitted along with the written documentation in the questionnaires.

"After filling in this section [of the questionnaire] *I have suddenly become aware of the possible harm from the materials I used (in and around home) when unemployed. Previously I had not been concerned about them and thought the proximity of the Sellafield and Chernobyl cloud the likely causes (or contributory factor) of my ill health. It has made me even more concerned about the future health of my children (both still at university) especially my daughter."*

Information pack design

One of Wen's primary aims is to inform people about issues which link environment and health particularly in relation to women. We reviewed the health requests WEN had received, particularly those connected with breast cancer, in the last few years. Common threads emerged and these were used as a basis for the type of information which went into the pack. As one woman commented:

[4] Common Ground is an organisation working with communities on Parish maps and helps to encourage people to value their own surroundings.

[5] Imperial Chemicals Industries – one of the world's largest coatings, speciality chemicals and materials companies.

"Your information pack gives some interesting and useful sources of further information, for example details of pollution incidents from nearby factories and if I had more time that is something I would like to pursue".

Distribution and publicity

The information pack needed to be publicised all over the UK. The best way to do this was through our existing network and local individuals. A mail-out to organisations and individuals was completed with a letter, a sample article, and a poster, asking them to publicise the pack and the project via their network, organisation, newsletter, minutes of meetings, local women's centre, library etc. This was followed up with a phone call to elicit support, strengthen bonds and discuss ideas about promotion and possible workshops. The requests came flooding in. Individual areas were not targeted at this stage, only existing networks.

One of our best allies for promotion of this project has been the Public Sector Trade Union, UNISON[6]. This is largely due to the fact that Unison was campaigning for Lindane, a pesticide linked to breast cancer, to be banned and the fact that they have a very large female membership. The project was promoted by the National Women's Committee in 1998 thus adding to its publicity among Unison's members. Several other national women's organisations such as the Women's Institute, and the Women's National Commission. the Inner Wheel[7], and Breast Cancer Care were instrumental in publicising the project amongst their members on a national scale.

A press release was distributed to all the national papers, radio stations, regional media, magazines and publications from other NGOs and organisations. Media coverage was good with the biggest response coming from an article in The Guardian. One women's magazine proved to be invaluable in getting the word out there. Utilising local media was an obvious way of promoting a local campaign. Participants were supported in contacting their local media as a means of raising awareness locally and facilitating the formation of a network. While it may be quite difficult to attract the attention of the national media to a particular issue, it is easier to tackle the local media for coverage of a particular local event or campaign. This was an essential part of the press strategy for promoting the project locally.

Workshop publicity

Workshops were devised around the pack. A list of aims and objectives was compiled and the workshop developed to cover each of the aims and fulfil each of the objectives. The areas in which we held workshops basically chose themselves within about a month or two of distributing the pack, as participants rang with questions or to ask us if we would do a workshop locally. Particular regions were chosen according to criteria such as: local demand for workshop, written requests for information packs, local key contact, availability of venue, willingness for different groups to be involved etc..

Once areas were identified, at least one local person was sought to organise a venue, do some publicity and to speak to the media about local environmental issues. This local 'key' contact was supported by the resources of the WEN office and by the project's staff to provide a point of contact for the developing network. Issues of confidentiality were observed by checking with people as to whether it was acceptable to pass on their details to the key person. Letters were sent out to anyone in the area who had sent for a pack and then any organisation local to the workshop. This was done about two to three weeks before the workshop date and in some cases a full month. WEN members were also mailed. A large number of workshops were facilitated by Unison through their Regional Women's Officers who co-ordinated the event and publicity.

The key person was asked which day and time was best and the timing of the workshops were varied in order to discover if any one time was better than another. This didn't prove the case. All local press were faxed and then phoned and asked to publicise the workshop and the project using the local contact as a source of more information. Participants who had

[6] UNISON – Public sector trade union with over 1.4 million members in the UK.

[7] One of the largest women's organisations in the world.

returned a questionnaire or request were contacted with details of workshop. On the evaluation sheet at the back of the questionnaire, participants were asked if they wished to be more involved in the project and in what way. This was used to assess if people wished to become a local contact point or work on the project with as little or as much participation as they could give.

Workshops

The workshops began with a pilot session, which was planned for members of the steering group of the project, the WEN Board and local women we had identified as having expressed particular interest in being involved. The feedback from this workshop was incorporated and used to modify proceedings in preparation for the next workshop. After the initial two to three workshops, the format was changed around dramatically, as it was found there was not enough time at the end of workshops to do justice to the map drawing exercise. It soon became clear that although current concerns and exposures were relevant, so too were participants past experiences going back to birth, given that contaminants and health problems may arise from as far back as twenty years or more. In some cases, pre birth exposures could have led to breast cancer or other health effects evident today. Participants were encouraged to map their life from the cradle to present day.

The geographical area covered by the workshops was extensive. We had workshops in England, Scotland and Wales but not Ireland. We were unable to cover a few areas where we had been invited, such as the Isle of Man. In some places, we were helped by volunteers, who became workshop facilitators. The attendance at our workshops varied greatly. A poor attendance in Bristol could have been because it was held on Bonfire Night (but the only time available to the women who organised the event in Bristol). We know some of the women involved in setting up workshops, and for some it was the first time they had organised anything like this, were disappointed with the turn-out. We had some discussion about what might hold people back from coming. Not being ready to talk about the issues may have been a major factor. On the other hand, we saw from the evaluation forms that many participants heard about the project from a wide range of sources including women's magazines, local press, local authority meetings, friends, through their union, through specialist journals etc. This indicates the project had an appeal to a very wide range of people and therefore attendance was not necessarily linked to content.

Attendance was certainly related to the amount of work that went into the organisation and one telling example is the Leeds workshop: 30 women attended after the local council had sent out around 1,000 invitations. Attendance was also linked to special conditions: in Boston, Lincolnshire, a good coverage in the local press brought in 20 people over the course of 4 hours. There is, of course, a great local concern about breast cancer in Lincolnshire, which has a higher than average incidence rate. When we went to more remote places, such as Launceston in Cornwall and Wales, the women who came were very gratified that a national organisation had made the effort to travel there.

Although we would liked to have done more workshops and to have met more women, we did get a wide cross-section of women attending the workshops, women with breast cancer, environmental activists, trade unionists, women from women's groups and health workers. For example in Cardiff, staff from the Cancer Registry attended the workshop leading to a good discussion among women who had experience of breast cancer and the group. In Hull a current and an ex-employee of the Ministry for Agriculture Fisheries and Food (MAFF) contributed alongside breast care nurses and activists from Friends of the Earth (FOE). We met our objective of getting together people looking at different parts of the breast cancer jigsaw and have started to form a unique network in England and Wales.

Observations by workshop participants

Positive comments indicated that the workshop was interesting, thoughtful and that it had raised awareness. Participants also stated that the mapping had been made easier through their involvement in the workshop. Criticism related to the complexity of issues. For example one person felt there had been a

lack of prior information; a few felt they had not had long enough to absorb the information; others wanted different kinds of information e.g. breast cancer information. On the other hand, some participants felt more information would have been overwhelming.

Specific suggestions were made for improvements in the workshops and future inclusions in our work:

- ensuring disabled access was *always* available;
- providing more positive advice on protecting our breasts and what we can do as individuals. For example breast-feeding was mentioned, as women need to know this has a protective effect for women who have babies at a young age;
- providing more information about breast cancer itself and about the environment;
- information about breast cancer in men and perhaps more targeting of men;
- scientific information more accessible; and,
- more focus on action and follow-up.

From the analysis of the workshops we can conclude that the most successful part was the content as people felt this to be thought provoking and informative. The most disappointing part of the workshop was the length; people felt they wanted more time. This was particularly true when the workshop had to be reduced to two hours due to constraints of time or availability of venue. From the comments we saw that some people wanted the time to discuss further action and follow up.

Observations and reflections of the facilitators

The time when we were organising, presenting and following-up on the workshops was a very intensive one for the team. At times we got quite fed up with the limitations of a privatised 'public' transport system especially when travelling to some of the more remote locations. Yet this was an exciting and very important experience. There was a positive two-way interaction between ourselves and the participants in the workshops, improving *our* understanding of many issues; we gathered information that we were able to feed *back* into the workshops.

The central focus on interactive mapping in the workshops was a powerful tool for drawing out both historical and/or environmental information. We were able to create group pictures of local concerns, where participants were able to spark off each other's ideas and recollections. Using 'fun' tools like fuzzy felts and bright coloured pens helped to demystify the whole mapping process. The environmental factors identified in the workshops were echoed in the respondents' maps. Flip charts were used to generate discussion about local sources of pollution and this information was used to compile a 'fuzzy felt' map of the locality to illustrate how participants could began to imagine their maps.

This information creates an interesting picture: pesticide use was highlighted universally, even though many women did not live in a rural area. Traffic pollution was a common worry. Heavy industry, in these de-industrialised times was not a large factor. The new commonly perceived industrial hazards seemed to be computing and photocopying. We also got some information which was relevant to the location, for example radon in Kettering or the dye works in Leicester. Through the mapping exercise, we created personal and individual histories which participants were able to share with each other. Sometimes we were able to experience the landscape we visited before jumping back on the train to London.

The free-ranging discussion and mapping in the workshop allowed us to broach, if not address in depth, various political issues such as the interaction between poor social and economic conditions and a poor environment. In some instances (e.g. in North Wales) we also talked about the difficulties of getting council and health authorities to even *listen* to our concerns. Most importantly we felt that we had given women who had breast cancer the chance to ask the question 'why me?' and to explore some of the possible answers. This was therapeutic but far more importantly it was empowering with a big 'E'.

• Next steps

The bringing together of the various strands of the process produced a dynamic and 'living' picture of breast cancer incidence in the UK and possible factors which affected it. When the completed maps and questionnaires were returned to WEN, each one was given a unique reference number. The information from the questionnaire was entered onto a database at the office and analysed. In order to get the maps onto the computer a picture was taken of each one using a scanner and this allowed it to be viewed on the screen and used in the report. With the co-operation of The London School of Hygiene and Tropical Medicine, a Geographic Information System (GIS) was set up to pinpoint and locate participants and local sources of environmental pollution identified. The idea was to link each questionnaire with the geographical point on the map which represents where participants had lived or are currently living.

From an analysis of the first 545 questionnaires received, 320 maps and contributions from 26 workshops, the project participants identified a large number of breast cancer clusters and a significant number of 'hotspots' for breast cancer. The term 'cluster' was defined as 3 or more cases of breast cancer occurrence in the same location, e.g. street or place of work, in the same time period. In addition, participants were very concerned about the high incidence of breast cancer in the UK, and the increase in health problems which have been linked to environmental pollutants such as asthma and hay fever. This was expressed especially in connection with air pollution from traffic and industry.

As a result of this project WEN has put forward a number of recommendations calling on the Government to commit a large part of annual health spending to a comprehensive programme for primary prevention of breast cancer. WEN also calls for a further analysis of Health Authority data on breast cancer incidence and prevalence by locality. We want prevention of breast cancer to be very high on the agenda.

WEN recommends making women and children's health the prime indicator of the state of the environment and acknowledging women's experience and knowledge about issues to do with their health. This could be utilised as a valid and valuable resource base from which to initiate official research programmes.

Including women as active participants in shaping this project 'Putting breast cancer on the map' has raised awareness, empowered and affirmed women's own knowledge. Women all over the UK have mobilised themselves to take forward the issue of breast cancer and environmental pollution. They are beginning to ask more questions, feel the strength of the network and develop the scope of the project beyond breast cancer to the larger issues of environmental impacts on both our health and that of future generations.

- **Helen Lynn,** Health Co-ordinator, Women's Environmental Network (WEN), P.O. Box 30626, London, E1 1TZ, UK. Tel: +44 (0) 20 7481 9004; Fax: +44 (0) 20 7481 9144; Email: artemis@gn.apc.org ; **Diana Ward,** Activist and Author, contact through WEN.; **Cathy Nugent,** Activist and Campaigner, Email: action@gn.apc.org; **Laura Potts,** Senior Tutor, Faculty of Social, Environmental, Health and Life Sciences, University College of Rippon, York and St. John, York, UK. Email: l.potts@ucrysj.ac.uk; **Liz Skan,** Activist and Campaigner. Email: lizskan@hotmail.com; and **Nicola Conway,** MA student at the University College of Rippon, York and St. John, York, UK.

NOTES

The above extract is from the *Putting Breast Cancer on the Map* Report. For a copy of the project report (priced £16 including post and packaging), the information pack (send an A4 sae with 66p stamp) or the Project Executive Summary (send an A4 sae with 39p stamp), please contact: Health Project, Women's Environmental Network (WEN), P.O. Box 30626, London, E1 1TZ, UK. Tel: +44 (0) 20 7481 9004; Fax: +44 (0) 20 7481 9144. Website: www.gn.apc.org/wen.

REFERENCES

Kelsey J.L., Bernstein L. Epidemiology and prevention of breast cancer. Annual Rev Public Health 17:47-67 (1996). McPherson

22

Preference ranking: a cautionary tale from Papua New Guinea

William J. Fielding and Janet Riley, with a response from Robert Chambers

Feedback is a forum for discussion in *PLA Notes*. It features articles which raise common concerns or challenges in fieldwork or training, together with a response from another practitioner of participatory approaches. Letters and articles are welcomed for this section, as are your comments on any of the issues raised by ***Feedback***.

• Introduction

Preference ranking is commonly used in participatory research to *understand* local people's preferences and priorities. These can include characteristics, aspects of a new farming method or more general development needs. Ordered lists are an important result of preference ranking, which can be used to guide researchers' future investigations or plan policies.

However, some problematical aspects of ranking and their interpretation have already been raised in *PLA Notes* (See Fielding, Riley & Oyejola, *PLA Notes* 33, October 1998). This article raised the importance of having a sufficient number of respondents in the study before differences in the ranked order of a list of items can be reliably identified. In the current article we discuss some ways in which ranking techniques can be misleading and limiting, and suggest some solutions. One method used to obtain a priority ranking of a list of items is to ask respondents to put each item in rank order; the numbers associated with the ranks are then added across all respondents and the totals are used to obtain an overall ranking from the group.

An example

Consider the following example. Four farmers are asked to rank five characters of a tree species using the numbers 1,2,3,4 and 5 to indicate worst to best respectively. In practice, farmers may be given counters to allocate to the items being ranked. Suppose the following ranks were obtained (see Table 1). The 'TOTAL' column, containing the sum of the numbers associated with the characters, can be used to give the overall preferences of the four farmers. In this exercise the farmers felt that the tree species was most useful as a building material.

Table 1. Example of a preference ranking method

Character	Farmer 1	Farmer 2	Farmer 3	Farmer 4	TOTAL
Fodder	1	2	2	3	8
Thatching	2	3	3	2	10
Straw	3	4	4	1	12
Fire wood	4	5	1	4	14
Building	5	1	5	5	16

An example using two methods of obtaining preferences

In the example above where five characters were ranked, farmers were asked to allocate the numbers 1,2,3,4 and 5 to each character. This system allows each respondent 15 'votes' to be allocated, but only in a specified way. Another method of obtaining preferences is scoring. Here there is a fixed total number of 'votes' or counters which respondents can allocate as they wish. The literature contains many examples of both ranking and scoring methods. But can the choice of method have an effect on the final ranks and hence conclusions? Does it matter which method is chosen?

In a recent biometry training session in Papua New Guinea, 13 researchers were asked to indicate the relative importance of five problems which were thought to be constraining agricultural production in the country. They were asked to do this using two different methods, so that the two methods could be compared:

- *System 1 (ranking):* they ranked the problems in order of importance using a simple 1, 2, 3, 4, 5 ranking system (as described above).

- *System 2 (scoring)*: they were asked to score the same five problems by allocating a total score of 25 'votes' between each of the five problems. Thus if a respondent considered all problems to be equally important, a score of 5 would be given to each; if only one problem is considered important this could be given 25 votes and the remaining problems no votes (see Table 2).

The total scores obtained from the researchers using Systems 1 and 2 are given in Table 2. It can be seen that although there is general agreement between the two ranking methods, different total rank orders are obtained. For example, using System 1, it seems that 'lack of suitable varieties' was regarded as the most important constraint. However, looking at the results from System 2, it appears that 'weed problems' are the greatest constraint. Thus it seems that the two methods have produced different results from the same group of people, to the same questions under the same conditions!

Statistical analysis was carried out to see if these rank orders were equivalent and, if not, which one was correct. The analysis revealed that there were statistically significant differences between the five totals. Using the same statistical technique for the corresponding 13 datasets in System 2, significant differences were also revealed between the five System 2 totals.

Thus, the statistical analysis indicates the differences in the scores are large enough for us to say that some problems really are more important than others. However, when multiple comparisons are calculated between the total scores within each system separately, the results indicate that there are different significant groupings in the two different total rank orderings and thus the order of the lists is not equivalent. If there were similar significantly different groupings in the two datasets, the two systems could be assumed to have generated equivalent results. The same would apply if no significant groupings were found in both datasets. Thus the statistical analysis indicates that the two methods have produced a different set of preferences, either or none of which may be correct.

Clearly we would not like our conclusions to be dependent upon the method used to collect the preferences. In the above example, the two methods produced different results from the same group of people, to the same questions under the same conditions. This is a worrying observation and it would require triangulation of the results (checking the results using data from other sources, if they exist) to verify which ordering is correct.

Table 2. Results from two preference methods

Problem	System 1 Only ranks 1 to 5 allowed	System 2 Scoring with a total of 25 'votes'
Weed problems	43	86
Pests and disease problem	43	73
Lack of suitable varieties	47	64
Poor market price	30	53
Lack of markets	32	49

Two preference methods discussed

System 1 is rigid and does not allow respondents to express their views in as much detail as System 2. An exercise which allows 15 votes to be split at will between 5 items and so allows for ties, is a system 2-type method. However, use of only 15 votes reduces the range of preferences which can be expressed**.** For this reason, the second ranking method may be preferred. However, the second method can be more confusing for participants; some of the researchers in this experiment failed to allocate exactly 25 votes. If they had been given exactly 25 counters and told to apportion all of them between the five problems, this would have overcome the problem. As a result of these demonstrated differences, it is reasonable to ask what properties a 'good' ranking/scoring method should have? We feel that an appropriate method should:

- allow each item to be equally preferred (i.e. given the same score);
- allow extreme preferences; and,
- be simple to administer/explain.

Ranking (System 1) always fails the first two properties listed above, whilst scoring (System 2) always allows equal ranking of the items. Scoring is also easy to administer/explain if the number of items being compared is small (six or less). If the number of items to be scored is exceptionally large (more than six), we suggest that for practical reasons five times as many counters as items are allocated between the items. So if there are eight items, 40 (5 times 8) counters are given to each person. Scoring also allows the possibility of greater differentiation between items which then makes it easier for the researcher to focus on items with similar scores and those which are extremely different to the next ranked item.

Because, as we have seen, the method chosen can influence the results, the interpretation of the scores must be made with caution. Simply applying statistical tests is not a solution because different tests can give different results (Riley & Fielding, 1998). Probably the best solution is for researchers to collect data from as many respondents as possible and look at groupings within the total rankings and investigate how each grouping differs from the next grouping down the ranked list. Then triangulation of results with other sources should be done whenever possible, in order to assess the validity of the study.

- **William J. Fielding,** P. O. Box CB 13789, Cable Beach, Nassau, The Bahamas. Email: fielding@batelnet.bs **and Janet Riley**, IACR-Rothamsted, Harpenden, AL5 2JQ. Email: janet.riley@bbsrc.ac.uk

ACKNOWLEDGEMENTS

The authors are grateful to participants of the Biometrics Training Course conducted at the Oil Palm Research Association, Papua New Guinea, for providing the data in this article. The course was funded by the European Union.

IACR-Rothamsted receives grant-aided support from the BBSRC of the UK.

Feedback… Feedback… Feedback…

- **Preference ranking: a response from Robert Chambers**

Fielding and Riley have illustrated the point made by Maxwell and Bart in *PLA Notes 22* (February 1995) that adding up numbers in ranking is statistically illegitimate and can mislead. One reason is that ranking does not show the size of interval. In this context, as they say, scoring methods are better. It is useful that they have also given a clear example of different results from adding up.

Two sets of comments seem pertinent. The first set is within the numbers paradigm. The second set is beyond it.
Within the numbers paradigm, the weaknesses of ranking compared with scoring have been explained in the article.

It is useful to go further and recognise that there are many different methods of scoring and estimating with matrices and that these have varied strengths and weaknesses. They can also be conducted with individuals or with groups. Those with statistical backgrounds may tend to prefer individuals to generate commensurable numbers. Some of the more commonly used methods (following and qualifying Maxwell and Bart 1995) include the following.

- *Scoring each box out of the same total.* This is the most common method. Each box is scored out of, say, 5 or 10 (16 has been used in Bangladesh for rice varieties). Boxes can be left blank.

- *Restricted scoring by column or row*. This allows the same fixed number of units to be distributed in each column or row.

- *Free scoring*. Allowing any number of counters to be placed in any box.

- *Voting systems*. Each person has a fixed number of counters and places these as votes. This is often preferred by people in the North, but is weak because late voters have more influence, having seen how earlier votes have gone.

- *Restricted overall scoring*. A fixed number of counters, often 100, are distributed between the boxes as scores.

- *Restricted overall estimating*. A fixed number of counters, often 100, are distributed between the boxes as estimates.

This is not the place for a detailed analysis but, in my judgement, the first, third and sixth points are the strongest.

- Scoring each box out of the same total is easily understood by participants, who usually quickly take over the process and argue freely. It is easy to inspect, interpret and discuss. It allows fine judgements and compromises.

- Free scoring overcomes problems of weighting. It allows an individual item to be heavily scored for a key characteristic in a way which is not as easy with any other method.

- Matrix estimating is a powerful method for estimating and allows adding up. If a total of 100 units are used, rows and columns can be added up to give percentages, for example of the relative importance of different crops in different agro-ecological zones. Beyond the numbers paradigm, there are several key points. Some of these are illustrated in Drinkwater's fascinating and revealing account of matrix scoring in Zambia (see *RRA Notes* 17, March 1993 pp. 24-28) 'Sorting fact from opinion: the use of a direct matrix to evaluate finger millet varieties':

- *Learning process.* Much of the value of matrix scoring is the process of analysis. Hearing the arguments, watching the interactions, sensing the power relations between individuals, and especially seeing how scores are debated and changed, can reveal more about the complexities, subtleties and variance in the realities and judgements than the scores themselves.

- *Whose analysis? Whose learning?* Farmer and other analysts themselves learn much from the process. As Drinkwater shows, they learn from one another. At the end of a good process they have a different understanding from the beginning.

- *Whose reality is expressed?* In any group certain individuals may dominate. Observing and interpreting interactions, and understanding the interests and views of dominant and subordinate individuals within a group deserves attention.

- *Empowerment*. Well facilitated, matrix scoring, like many other PRA-type methods, empowers the 'lowers' who carry them out. In some of my recent field experience in Eritrea, it was after matrix estimating that the village leader changed from *"whatever the government says is best"* to *"now you can see why your land policy will not work"*.

A valuable part of the process is often the discussion which follows, using the matrix as a visible agenda from which items can be picked out. This can be a wonderful experience of learning, often about topics one did not know to ask about.

Thus it is often the non-numerical aspects which matter. As practitioners, we need to exercise care to keep the reductionism of numbers and statistics in their place as useful tools, applied where appropriate to illuminate and enlighten, but not allowed to divert us from process and learning. For the realities which are analysed and shared are often complex, diverse and dynamic and are mediated through judgements and interactions. It is through facilitating good judgement and interactions that we can find ways of doing better.

- **Robert Chambers,** c/o Institute of Development Studies (IDS), University of Sussex, Brighton, BN1 9RE, UK. Email: r.chambers@ids.ac.uk

• Authors' reply

We are grateful to Dr. Chambers for his comments and we just like to add a few of our own. As Dr. Chambers points out, the discussion process involved in any scoring/ranking method may be more informative than the numbers which are collected. Therefore, the exercise is useful in the *understanding* aspect of participatory studies, which is one of its key features. This is something not necessarily reflected in the data.

However, it is increasingly difficult to escape the 'numbers paradigm' and, as decision makers look for justification for their choices, numbers are an obvious support to them. Therefore, the researcher must, however reluctantly, be able to assess the limitations of the conclusions associated with a data set, so that a reliable interpretation is put on the data. In this context, statistical methods can be useful.

As Maxwell & Frankenberger (1995) write: 'It is important to recognise that both quantitative and qualitative techniques are tools that play a useful and complementary role in improving our understanding' and that 'sampling considerations also apply to qualitative information'. What this real example shows is that the interpretation on a set of preferences depends upon the method of data collection and the method of analysis. Therefore, any interpretation of this type of data probably should not be made solely via statistical analysis. Thus we conclude that there is a need for checking results from other studies.

REFERENCE

Maxwell, S and Frankenberger, T R (1995) Household Food Security: Concepts, Indicators, Measurements. UNICEF/IFAD.

23

Tips for trainers: Analysing personal dilemmas

Randini Wanduragala

• Introduction

This is a way in which staff of an agency can be helped to link some of the root causes and possible needs of a situation to the particular dilemmas of individuals in communities with whom they are working. This exercise is suitable for groups with a maximum of 20 participants, although a smaller group is preferable. The group can be either mixed or single-sex.

Time required: 30 minutes

• Preparation

Find a quote from a local magazine, a radio programme or book and type it up on the middle of a sheet of paper. It is best to have one copy of this sheet of paper for each participant. The more local the quote the better, since it will help staff to focus better on local needs. If you have time, it would also be good to have the same quote printed large on one piece of flip-chart paper for a second stage of the exercise. You will need pens, prepared sheets of paper, prepared flip-chart sheet, post-it stickers/blank cards, marker pens

• Method

- Distribute one sheet of paper with the quote to each participant, then ask them to read the quote quietly to themselves and to think about it for a minute or two.
- Next, encourage participants to split into groups of two or three. These can be mixed groups of men and women or single-sex groups; it's up to you, which you think will work better. They should start to think together about the wider issues which relate to the dilemmas facing the individual in the quote, such as poverty, environmental degradation, healthcare needs etc. It might help for you just to give two or three suggestions like this, just to start them off. Ask them to write *brief* key words for these issues around the edge of the paper, in a circle around the quote.
- Once everyone has written down some key issues for themselves, ask them to draw lines to link specific parts of the quote with the key issues that they have written down. You could give an example, suggesting that they link part of the quote you have chosen with, for example, health care needs, to help them understand what you are asking.
- Give each pair a few more minutes to do this. Each pair should now have a page criss-crossed with lines, joining the original quote to the keywords that they have added.
- Now ask all the participants what this exercise has taught them about this subject and encourage some open discussion.
- Then, if you have time, compare everyone's analysis, since some pairs may have thought of different key words. For this, it would be best to have your quote printed largely in the centre of a piece of flip-chart paper. Ask each pair quickly to write their key words on post-it stickers or cards and to stick them around the outer part of this flip-chart. Next you can ask two volunteers to group the key words, according to their subject. For instance, all the key words to do with poverty can go in the top left corner; all those to do with belief systems can go in the top right corner, and so on (see Figure 1).

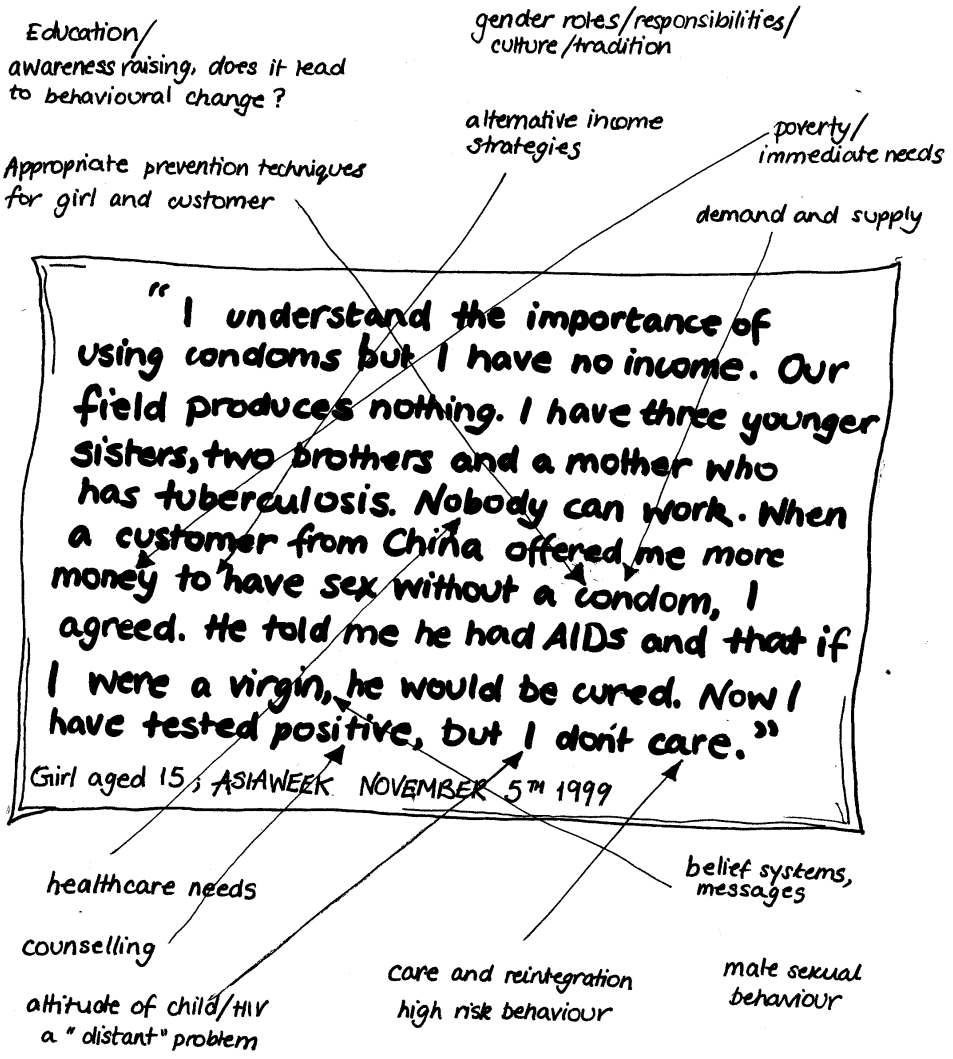

Figure 1. Sheet linking quotes to wider issues as identified by participants

- When this has been done, ask participants to gather around the flip-chart and see if there are any key words written up which some participants may have not included in their own analysis, or which they may disagree with.

One likely contentious key word may be to do with gender issues, for instance. In this case, ask the participants who included it to explain their reasons for doing so. Ask those who didn't to explain their reasons for excluding it. More discussion is likely to follow. Try to make sure it doesn't collapse into an argument though!

• Conclusion

This exercise should help staff members to link a theoretical understanding of the issues involved in HIV to the personal dilemmas of individuals in the communities with whom they are working. This can help them to use their theoretical knowledge to address practical issues; it can also help them to recognise that HIV is far more than "just" a health problem.

- **Randini Wanduragala,** World Vision UK, World Vision House, 599 Avebury Boulevard, Milton Keynes, MK9 3PG, UK. Tel: +44 (0) 1908 841 000; Fax: +44 (0) 1908 841 001.