

**"Strengthening PRA skills for qualitative research within
CoBaSys African and European Research teams"
PARTICIPATORY REFLECTION and ACTION RESEARCH
METHODS FOR COMMUNITY BASED SYSTEMS ON HIV
TREATMENT:
TRAINING WORKSHOP REPORT**

An ACP-EU co-operation programme in the field of science and technology



**Training and Research Support Centre (TARSC) with
Community Based Systems in HIV Treatment (CoBaSys)
research teams and the
African, Caribbean and Pacific Group of States (ACP
Secretariat)**



In Zimbabwe, Malawi, Namibia, Botswana, Mozambique and Tanzania



Source: TARSC 2010

Harare Zimbabwe; April 22- April 24 2010

**Report produced by TARSC
Meeting held with support from the European Commission**

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1. Background

The participatory Reflection and Action (PRA) Research Protocol training for community based Systems in HIV treatment (CoBaSys) was hosted by the Training and Research Support Centre (TARSC) in Harare Zimbabwe from the 22nd-24th of April 2010. It involved 13 delegates from the CoBaSys partners in Europe, east and southern Africa (see delegates list in appendix one). It aimed at training CoBaSys PRA focus group teams in Zimbabwe, Malawi, Mozambique, Namibia, Botswana and Tanzania on the use of the PRA protocol for primary data. The training meeting was building a foundation for primary research and a shared understanding of the nature of participatory action research approach, expected needs, capacities and skills to implement it.

PRA research is a method for both gathering evidence and setting a platform for action. It builds reflection within communities in a bottom up process by involving all relevant parties in actively examining action in order to change and improve it. Thus, PRA research involves direct participation in a dynamic process, while monitoring and evaluating the effects of collective actions, with the aim of improving practice in order to increase understanding of how change in actions/ practices mutually benefit a community.

To enable this, TARSC developed a PRA research protocol that sets up the work led by TARSC in the broader ACP "*community based systems in HIV treatment*" work supported by the European Commission. The PRA work introduces processes in communities in Zimbabwe, Tanzania, Namibia, Botswana, Malawi and Mozambique that set the needs, capacities and priorities for community systems for management of HIV and AIDS. It follows visits to the communities to introduce and strengthen the participatory research processes in HIV treatment responses at community level. The tools aim to support researchers and communities to map the social groups and features of communities, to explore the factors that facilitate and block access to, use and effective coverage of services and responses to HIV, and to identify relevant and effective approaches to building community systems for responding to HIV and AIDS and services that support these systems. The tools will be used by facilitators for use in different social, political and cultural settings, to enable communities and service personnel to identify and build shared perceptions of priority needs and strategies that are sensitive to different policy, socio-economic, political and civil society contexts.

Thus, the first stage of the three day training meeting identified the PRA approach, the protocol, and key facilitation and reporting skills in identifying and realising determinants and priorities that guide the community systems in HIV treatment, fundamental to subsequent processes, as recognised in the wider research framework of the project. While this process looked at understanding use and interpretation of the PRA tools in the protocol, it also was a platform to agree with partners on feedback mechanisms, mentoring processes and platforms by TARSC, compiling minutes for website, quality control and checks, synthesis of primary research data in all six countries by TARSC. The second stage of the training involved a practical approach to the training for the researcher's practise in using the tools in the community. This was done in Goromonzi Rural District in Zimbabwe, a district that is already part of the Zimbabwe CoBaSys research sites with 30 participants. These participants were drawn from several wards in the Goromonzi District and represented health workers, local authorities, opinion leaders, traditional leaders, People living with HIV/AIDS, youth, women, men and other stakeholders (see appendix two for the community participant list)

2. The CoBaSys PRA training meeting thus aimed to:

- Train and equip CoBaSys PRA research partners with understanding and skills to use the PRA research protocol for primary research to ensure that researchers are clear about the implications this goal has for the way the tools are used and reported

- Provide a practical experience on the use of the tools by getting partners into the field to witness first hand participatory approaches in action at community level to provide guidance on the implications for planning, implementation, recording and feedback.
- Collectively agree on approaches of compiling, synthesis and consolidation of data including timeframes and implementation of subsequent work package areas.
- Inspire team work and understand the strategic role of each partner in primary research for future areas of work.

The training meeting was held in the context of CoBaSys main objectives on “**empowering local communities fighting HIV/AIDS**” with specific emphasis on Work package 2 (WP2) objectives and deliverables:

- **Objective:** Developing, building capacities for, implementing, reporting and engaging on the participatory and complementary quantitative approaches at community level
- **Task:** Capacity support and orientation, including on participatory reflection and action research (PRA) methods of facilitators of project activities within the country pilot areas



Training activity

Source: F Machingura TARSC April 2010

The PRA protocol¹ is separately available and provides the detail on the sessions and how they were conducted so this report doesn't record this detail. The protocol is accompanied by a recording book² that will be used by the Researcher and his/her PRA research team to record data verbatim, at community level during PRA meetings. This is

based on the collective understanding that PRA meetings, allow for more nuanced, semi-structured and open-ended responses. Thus, it is imperative to capture values, attitudes, practices and preferences of participants to permeate the 'how' and the 'why' underlying a phenomenon. The meeting involved dialogue and exchange of experiences, activities to encourage reflection and discussions on follow up (see programme in appendix three). This report will reflect some of the diverse exchanges that took place in the meeting, captured through quotes, pictures and some major agreed areas of action.

¹ Machingura F, with peer review input from Loewenson R, Woodhouse P, Kaim B, and CoBaSys PRA research teams (2010); Participatory Research Protocol for Community PRA meetings in community based HIV treatment in Zimbabwe, Malawi, Tanzania, Botswana, Namibia and Mozambique; TARSC: Harare

² Machingura F. (2010) Participatory Research Protocol recording book for Community PRA meetings in community based HIV treatment in Zimbabwe, Malawi, Tanzania, Botswana, Namibia and Mozambique; TARSC: Harare

2. Introductions and overview of PRA work done by TARSC

Ms Fortunate Machingura from TARSC welcomed Delegates to the CoBaSys PRA training meeting and outlined the objectives of the meeting. She noted that the meeting focused on training and equipping CoBaSys PRA research partners with skills to use the PRA research protocol for primary research and to ensure that researchers are clear about the implications this goal has for the way the tools are used and reported. The meeting also provided with practical experience on the use of the tools at community level to provide guidance on the implications for planning, implementation, recording and feedback.

Ms Barbra Kaim from TARSC gave an overview of TARSC work on PRA. The Work on Participatory Reflection and Action (PRA) at TARSC is based on the values and fundamentals of understanding that different social groups at grassroots levels in our communities have unprecedented potential to assess their priority health needs based on their experiences and conditions of life. Thus, communities are capable to make their own decisions about how to effect change to advance health and ultimately shape their future. Ms Kaim noted that TARSC and the Ifakara Health Institute under the EQUINET umbrella have since 2005 been carrying out capacity building on participatory reflection and action (PRA) methods for research and training for a People Centred Health System. This work has been implemented in the context of EQUINET's overall work on building people centred health systems. She added that, the work aims to bring together the knowledge, capacities, social networking and practice that brings people led, people centered, primary health care oriented health systems that organize, empower, value and entitle people in the ESA region. It is based on the values of equity, social justice and the right to health.

TARSC has a history of work on PRA methods backdating to 1994 (16 years) and has produced toolkits, manuals, papers, and other publications on PRA research, training and social empowerment. The work has targeted both national and district/community level cadreship to enable capacity building and research using participatory action methods. The work has been used to directly link research to action and change at primary health care service and community levels in Health worker-community interactions, in PHC oriented responses to AIDS, Health Literacy, public and social accountability in health and in providing an eye on equity using photography.

3. Understanding the PRA protocol for CoBaSys PRA research meetings

Ms Machingura highlighted the framework of the PRA protocol, its purpose and how it's organised. The protocol identifies and defines CoBaSys' collective understanding of terms, highlights existing literature, defines the steps for implementation and stages the methodology. It further gives detailed steps and tools to use when conducting PRA meetings over a three day period in each of the target districts. The tools aim to support researchers and communities to map the social groups and features of communities, to explore the factors that facilitate and block access to, use and effective coverage of services and responses to HIV, and to identify relevant and effective approaches to building community systems for responding to HIV and AIDS and services that support these systems. The tools work in different social, political and cultural settings and enable communities and service personnel to identify and build shared perceptions of priority needs and strategies that are sensitive to different policy, socio-economic, political and civil society contexts.

She added that most of the tools in the PRA protocol were drawn from EQUINET, TARSC, Ifakara toolkit on participatory methods for a people centered Health systems – *Organising people's power for health* (Loewenson R et al (2006)³, the guide for participatory meetings

³ Loewenson R, Kaim B, Mbuyita S, Chikomo F, Makemba A, Ngulube TJ (2006) Participatory methods for people centred health systems A toolkit for PRA methods, TARSC, Ifakara , Ideas Studio, Harare

with communities on prioritizing local resource allocation (TARSC 2009)⁴ and the Health Literacy Manuals for People centered Health systems for Zimbabwe⁵, Malawi⁶ and Botswana⁷. All these materials draw from knowledge and experience of individuals and institutions working at community level in health.

Ms Machingura acknowledged that while the partners involved in PRA meetings for primary research may have familiarity with use of PRA tools, it was important to note that the tools in the protocol were to be used in a qualitative research mode. The PRA training for partners ensured that facilitator/researchers were clear about the use of the Protocol, particularly on standardisation of the research methodology in east and southern Africa. The PRA research protocol emphasizes the importance of realizing the creative capacity of participants to explore, understand and address challenges, and of encouraging them, from the outset, to assume ownership of the process of problem exploration, analysis and solution in HIV treatment at community level.

Thus, it is important to understand that the methods need to be implemented in a manner that is able to achieve target outcomes. This places a responsibility on the facilitator to capably facilitate, manage and record these processes, so they achieve these outcomes. This calls for capacity building of the facilitators. Ms Machingura added that the PRA protocol would be accompanied by a recording book that enables the facilitator to capture values, attitudes, practices and preferences of participants to permeate the 'how' and the 'why' underlying a phenomenon while still in the field. Since data resulting from qualitative research approaches does not lend itself to numerical coding, evaluation of qualitative findings is more complex compared to quantitative research results. Consequently, she encouraged researchers to stimulate discussions, and probe for interactive discussions to appreciate a deeper understanding of issues in the field.



Discussion on PRA methods

Source: TARSC 2010

⁴ TARSC (2009) Strengthening community participation in equitable resource allocation for health- Guide for participatory meetings with communities on prioritizing local resource allocation: Zimbabwe, TARSC: Harare

⁵ Loewenson R, Kaim B, Machingura F (TARSC) Rusike I, Chigariro T, Mashingaidze L, Makone A (CWGH) (2007) Health Literacy guide for people centred health systems: Zimbabwe, TARSC: Zimbabwe

⁶ Loewenson R, Kaim B, Machingura F (TARSC) Kawale P, Kwataine M (MHEN) (2008) Health Literacy Manual for people centred health systems: Malawi, TARSC: Harare

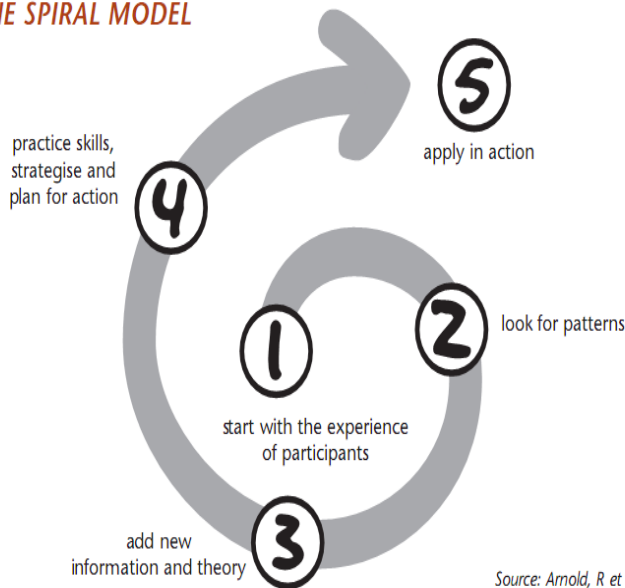
⁷ Loewenson R, Kaim B, Machingura F (TARSC) Kelemi C (BONELA), Mhotsha G (BFTU) (2009) Health Literacy guide for people centred health systems: Botswana, TARSC: Harare

4. Research using participatory approaches

In buzz teams participants brainstormed on the characteristics and key features of participatory approaches in research. Common to the feedback included common terms such as: empowerment, involvement, sharing and discussions. Some of the reflections from participants included:

“Participatory approaches and processes in research results in learning and empowerment that takes place in communities. These are important benefits in research that are often overlooked”. Thabo Seleke-Botswana:

THE SPIRAL MODEL

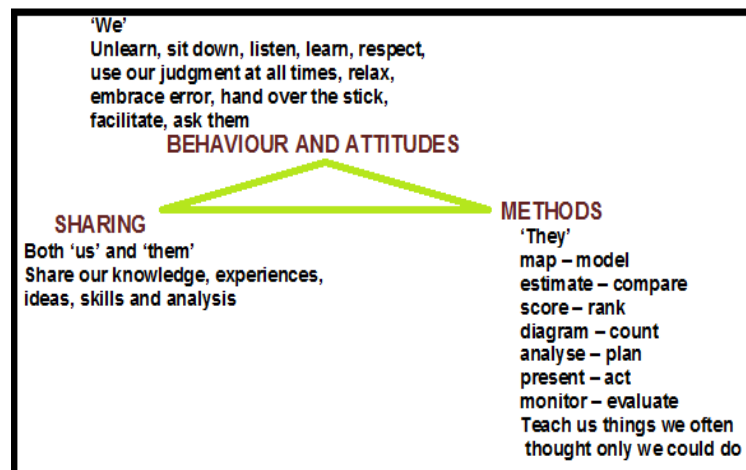


Source: Arnold, R et al (1991)

“A participatory process often gives more control of the methodology of research by communities and respects the knowledge communities have of working with communities, however, to maintain the scientific rigor in participatory research these changes must be made in a structured way, and not done in an ad hoc manner as and when the need arises. To ensure this is possible, training must be used to teach not only methodologies, but the underlying principles of participation” Fortunate Machingura- Zimbabwe:

“Participatory processes in research demand creation of space for the sharing of ideas, and creating mechanisms that allow for collaboration between different stakeholders in the community utilising the expertise on-the-ground knowledge of the people working in health” McDonald Kufankomwe-Malawi:

Ms Senele Dhlomo (TARSC) guided a discussion on basic principles, methods and goals of PRA emphasizing the transformative nature of PRA. Using pictorial case study participants discussed how and why PRA methods are central to community based research particularly on how PRA allows relevant developments central to people’s needs. Following this, we recognised components that put into practice some basic principles of PRA. We identified these as ‘the three pillars of PRA’



Source: Loewenson et al (2006)

fundamental in the implementation of participatory research (see adjacent figure). Specifically they include: ‘the attitudes and behaviour of facilitators, sharing between facilitators and the community and the use of a wide range of participatory tools’.

Participatory processes can be represented by a spiral with a regular cycle of reflection and action, from this a community can draw lessons from their experiences and continue to find better solutions to their difficulties, this continues to move them closer to their positive change in their lives. Thus, in participatory research participants were encouraged to capture values, attitudes, practices and preferences of communities to appreciate a deeper understanding of issues. We noted that a qualitative research approach does not lend itself to numerical coding; therefore researchers need to have the skills to stimulate discussions, and probe for interactive discussions at each reflection point of the cycle. The basic approach of reflection gives communities opportunities to share their opinions and contribute to decisions or plans being or that can be developed encouraging a bottom-up approach.

5. PRA meeting activities

5.1. Social mapping and interviewing the map

We looked at the different ways of mapping and analysing communities. We discussed the different elements that make up communities, and how we understand the term 'community'. We drew social 'maps' of a typical community and explored the type of features that these maps might include, and how they can be used to identify the different social groups and influences on health in an area by interviewing the map. We conclude that if local people and communities are to engage effectively with the processes of change, they need to know what is going on, understand how proposed changes may affect them and to feel confident that they can play a positive role in those changes. Mapping is a powerful way to engage local communities as well as visually representing their information, helping to draw new links and ideas. The ability to access a social map that provides information on anything from health services to education, support organizations to transport, provides a way in which people interested in their community can find out what is going on and those operating within the community can promote their services and activities. Bringing information based on local knowledge to a situation can help challenge top-down views and help create positive transformations in the community.



Social mapping:

Source TARSC 2010

5.2. Prioritising health issues in our community

Participants were divided into fictitious social groups where they identified and listed their health problems. Each participant was given an equal number of bean seed which they were asked to distribute according to priority from the listed health problems. The more seeds, the higher the ranking. Ms Machingura led a discussion on the differences and similarities among the groups and the reason for their findings. We realised that this particular tool enables the researcher to get to understand the actual needs and health problems of communities without presumptively prelisting likely problems for communities to choose from a list (as is normal in quantitative research). Communities will want to make the health services understand their health needs and priorities. The ranking method is one way of doing this, and presenting and discussing the findings at a district health meeting can enable communities to begin working on their problems collectively by engaging with local authorities and other key stakeholders.

5.3. Identifying causes of priority health needs and actions for these causes

We used the problem tree to look at a number of the health problems prioritised, identifying the immediate, intermediate and underlying causes while also interrogating the causes of the



causes to get more deeply into understanding of the priority problem of each social group. We went further to explore actions that communities could take for these causes. We realised that when we look for causes we can explore different levels of causes and go beyond the immediate causes to cross-examine the 'causes of the causes' enabling us to address problems for a wider number of people. Each cause has a different level of solution, and communities play a pivotal role in addressing their health problems at each level, but also need partnerships with those who also have power to act at different levels.

Source TARSC 2010

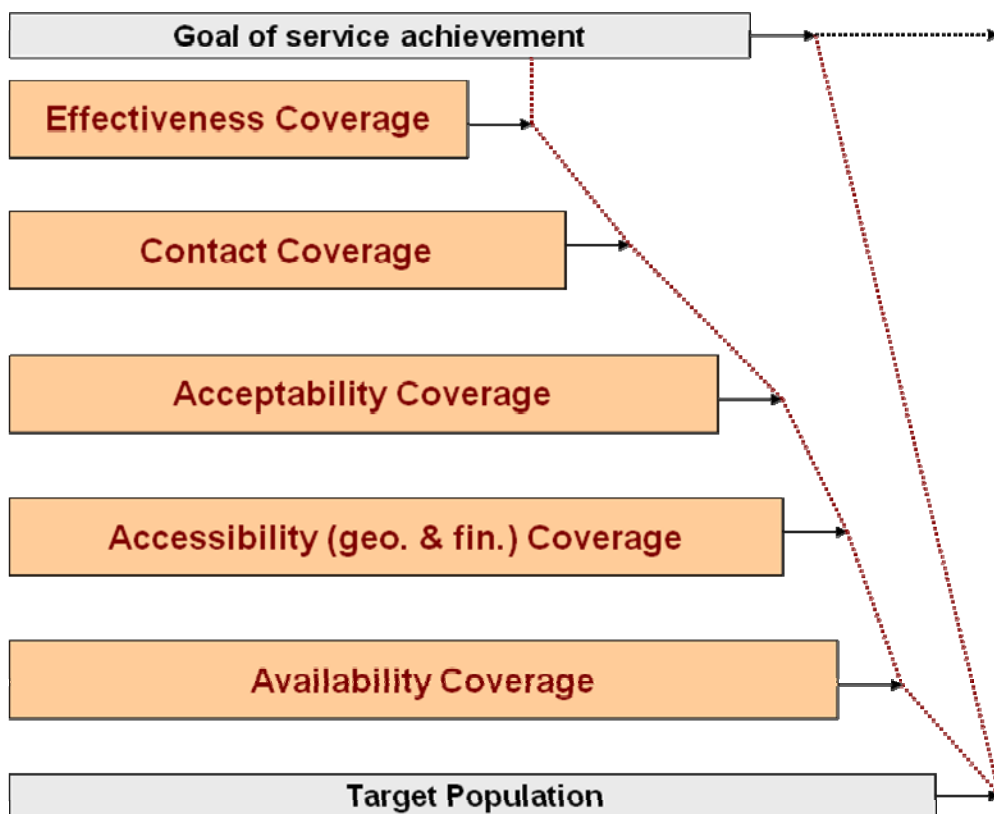
Love Masanjala: "By using participatory tools for research, I feel like, our role as PRA researchers is to make these problems visible to experts, but communities also gather and can use evidence on how health problems are affecting their communities"

5.4. Effective coverage of community HIV AIDS responses.

We used the Tanahashi (1978) model to explain / communicate the concepts of coverage and measure achievement on coverage. Ms Machingura noted that effective coverage identifies the magnitude of the realized health gain from the intervention relative to the potential health gain possible with the optimal performance of the providers for a given health system. Using the diagram below participants were asked to get into selected social groups to identify for that social group the services and resources that available but where effective coverage was low.

On each step of coverage (availability, accessibility and acceptability), participants identified the factors, services and resources for AIDS that are found for the social group identified and services and resources that are not found outside the step. On contact coverage participants listed the resources and services that were being used and outside the step those that were not being used.

Tanahashi: Health Service Coverage Diagram



Source: Tanahashi T. Bulletin of the World Health Organization, 1978, 56 (2)

Ms Machingura highlighted that, using this model in participatory research was fundamental in permeating an understanding of underlying issues around how HIV/AIDS resources should be allocated and how they should be organised in order to effectively serve the wider target group. The tool enables the researcher to understand if services are reaching the people they should serve and if service has been effective in meeting the target population needs while also allowing communities to proffer recommendations on how disabling factors should be addressed.

Participants realised that it is unlikely that a single measurement of coverage could satisfactorily reflect the complex interaction between the health service and the target population, thus, using the five domains of coverage at community level would be effective in understanding the interactions deeply.

5.5. Systems and mechanisms for Referral care

Understanding referral care at community level for HIV services is fundamental in understanding HIV treatment responses at primary care level. Using the focus group guide (in the PRA research protocol) participants were divided into two fictitious working groups (Communities and Health workers). Communities discussed the referral network at

community level and the patient flow at health centre level while health workers discussed clinical mentoring within health care institutions and the patient flow at both clinic and district level.



Source TARSC 2010

5.6. Linking actions to providers and the role of stakeholders in HIV treatment

The stakeholder mapping and the roundtable discussion raised a number of questions on how to strengthen support to HIV/AIDS services at community level. It highlighted ways to fill the gaps in access to HIV AIDS health inputs; ways to improve coverage of educational support to OVC, PLWA, women and other vulnerable groups affected by HIV AIDS.

Some of issues that we agreed to interrogate at community level during research include:

- How do we map the resources, institutions and actors available at community and primary care level to respond to the epidemic?
- How do we support groups, referral network at primary care level? What is the role of each actor including communities and what else should these actors do?
- How do we ensure coordination between different actors providing the same support to PLWA and those affected?
- How do we collectively support those (organizations /individuals) in closest contact with PLWHA?
- What actions should be prioritized by the stakeholders at community level to support HIV treatment, support and care
- Are resources equitably distributed and what changes should be made to the way stakeholder and the resources they provide are distributed in the district?
- How can communities control their own resources for health for equitable distribution of these resources and what can communities do to influence health spending so it is in line with health priorities and actions?

- What support do we expect from the District AIDS Action committees, the national AID council and other stakeholders dealing with HIV at national level to enable access to resources and information to those who need it the most.

5.7. Understanding determinants of community HIV treatment systems

Using the leaping blocks tool, we explored the enabling and disabling factors towards achievement of a people centred health system that responds to HIV AIDS services, information and resources at community level. We further explored some of the issues that should be added to facilitate this outcome. Participants noted that the objective of the tool was to also note what communities can do on their own, and what health workers can do on their own and what could be done collectively. The tools make it possible for communities to see that collective efforts are more effective than selective initiatives that only respond to health worker needs or just communities needs but both.

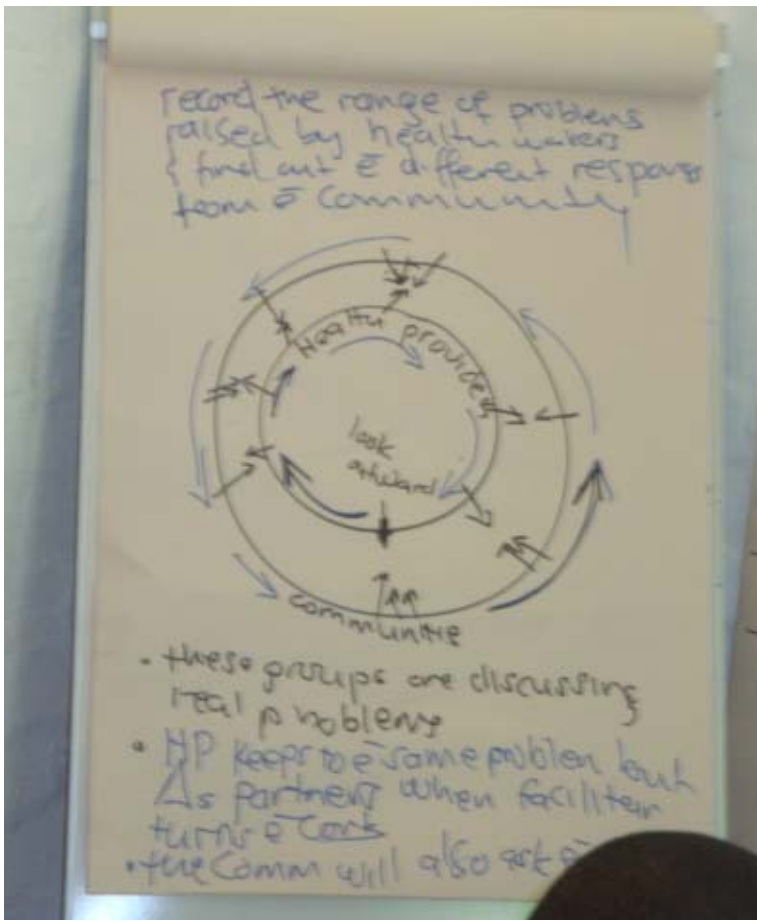
Some key issues that emanated from this discussion included:

- The need for facilitator to refer back to previous activities and encourage a deeper and closer discussion on factors and how they affect the system
- The importance for the research team/facilitating team to work as a team as this activity can be rich and very useful in consolidating discussions, issues and critical components of this research.

5.8. Communication between patients and Health workers

The one critical mechanism for strengthening community based systems of HIV treatment is strengthening the relationship and communication between health workers and communities.

To illustrate how this method can stimulate discussion in participatory research we used the Margolis wheel and the spider diagram tool. Participants were divided into two groups, i.e. Health workers and communities. Each group formed a circle one inside circle and one outside circle and participants in the inside circle faced those in the outside circle. In these interacting wheels, health workers and community members major communication problems and suggested solutions for each other.



- It is critical to listen to discussions in progress and the research team should be recording the dialogue in progress
- When each group is reporting on their dialogue (problems and solutions) facilitators should probe further for more information to get a deeper understanding of issues.

6. Recommendations

The market place approach was reviewed as a means of drawing out information and options where there is need for debate. It was noted that a great *quantity of information* can be generated; also a *quality of information* can be generated including new information from community level, opinion leaders and other stakeholders. Some reflections from this tool included:

- *This format allows for free expression there are no right or wrong opinions*
- *It allows opportunity for discussion and opens the mind*
- *It allows for exchange of views through reading and writing and also discussion between people at different 'kiosks' in the market place*
- *Everyone has an equal say and contribution have equal value*
- *The role of the facilitator is crucial to guide and support the process.*

7. Next steps and key action areas

There was a follow up discussion on the role of the participants as 'facilitators' for follow up processes, feedback, timelines, report writing and recording the data

7.1. Research teams and recording of information

- Lead researcher, trained by TARSC on the use of the protocol should have a team of facilitators (about 4-6 members) that he/she will train. Each member of the team will have facilitating roles and rapporteuring roles.
- Each facilitator from the research team should carry their own recording book, to record information during group work, in plenary, during activities and discussions while the meeting is taking place.
- Research teams should meet and discuss at the end of each day to complete all sections in the recording book and share notes, that will be handed over to the team compiling the report.
- Each country research team is encouraged to have one completed and double checked record book with all the information combined from facilitators before leaving the area so that it can be verified by all facilitators as an accurate record of the proceedings.
- Research teams are expected to be '**facilitators**' during research instead of '**experts**'.
- If possible put together an interdisciplinary research team: perhaps one person who is knowledgeable in the subject you are researching, another who is an experienced PRA facilitator (could be a member from an institution that has done so PRA work with TARSC and or with EQUINET), another person knowledgeable about the target area/community/district you're working in, etc. In this way, each team member brings in different perspective, different strengths. However all should be trained on how to use the CoBaSys PRA protocol

7.2. What is expected of a CoBaSys PRA research facilitator?

As facilitators during PRA meetings, participants are expected to

- Allocate tasks, explain the objectives of the discussion, as well as the whole exercise to the group/community and prepare all required equipment and materials.
- Guide activities through probing (provide explanation when required); stimulate discussion, and bring attention to motivate full participation by all.
- Diplomatically control dominant participants and guide the group members so that they remain focused to the matter at hand.
- Adhere to the time allocated and avoid long tiresome discussion.

7.3. Characteristics of a CoBaSys PRA Research Facilitator:

This means that facilitators need particular characteristics:

- To be cheerful, patient, attentive, quick to learn people's names and quick also to change the direction of discussions as appropriate.
- To be capable of instilling self-confidence among other people in order that they are encouraged to contribute their ideas.
- To be constantly aware that facilitation is neither teaching nor instructing, but guiding people through the PRA process
- To be consistent, follow up and evaluate together with the community members the whole process and the plan.
- Read and understand the target areas so that they can facilitate guided and informed discussions.

7.4. Timelines, reporting-back and quality control

- Participants agreed that each country team would conduct primary research and record issues from the PRA meetings in the CoBaSys PRA meeting recording book.
- The record book will be used 'as a means of verification' for conducting PRA meetings using the agreed collective methodology.
- Each country is responsible for developing its country report that will be sent to TARSC.
- TARSC will consolidate the country reports into one publication. However a report of each district from each country is expected to be sent to TARSC within one month of conducting the research.
- All country teams are expected to have completed the PRA meetings and reports by October 30th 2010



Source: TARSC 2010

8. The field experience

Participants were each allocated a facilitation role at community level to practice skills gained at the two day training meeting. The training session at community level used real population targets and target social groups in the Rural Goromonzi district. The meeting was held at the Shelly Cripps Children's home in the Chikwaka Ward. The meeting participants were drawn from the Ministry of Health and Child Welfare, local authorities, communities, women's groups and church organisations (see community participant list in appendix three)

The following summarises some reflections on the training from participants



Source TARSC 2010

"Putting the PRA tools in practice at Goromonzi district on Saturday the 24th April 2010 was Quite phenomenal, challenging and gave positive feedback in what we can do in our respective countries" Thabo Seleke-Botswana



Source TARSC 2010

"As clearly evidenced from the Goromonzi district the PRA tools require a team of about four members or more who will need to carry out the exercise and it is upon us to ensure that thorough work is carried out in our respective countries and I take it that TARSC will play the lead and give guidance to the process" Love Masanjala-Malawi

"This was quite a remarkable training, great work, it's upon us to excel"- Kenneth Matengu-Namibia

“This training was worthwhile and I have no doubt that having tested the PRA tools as we did we will achieve our respective mandates” Emidio Guni-Mozambique



“This is a platform to strengthen communication and dialogue and to promote team spirit, this work area led by TARSC is setting the foundation for subsequent areas, so let’s continue working together” Francesco Guaraldi-Italy

“The protocol is quite thorough and the tools are very dynamic, it’s a pity I came a bit late,

but this process is quite new and exciting” Katri Kontio- Finland

“I’ve been trained on PRA methods by TARSC before, but the CoBaSys protocol is quite unique for community systems on HIV treatment, I think this will be interesting, it enables the facilitator to dig deeper and deeper, so get as much information but manage your time!

Edgar Mutasa- Zimbabwe



9. Appendices

9.1. Appendix one: Partners Delegates List

NAME	COUNTRY	ORGANISATION/UNIVERSITY
1. Emidio Guni	Mozambique	University of Eduardo Mondhlane
2. Fortunate Machingura	Zimbabwe	Training and Research Support Centre
3. Senele Dhlomo	Zimbabwe	Training and Research Support Centre
4. Mavice Makandwa	Zimbabwe	Training and Research Support Centre
5. Thabo Seleke	Botswana	University of Botswana
6. Kenneth Matengu	Namibia	University of Namibia
7. McDonald Kufankomwe	Malawi	REACH Trust
8. Love Masanjala	Malawi	University of Malawi
9. Barbra Kaim	Zimbabwe	Training and Research Support Centre
10. Esther Sharara	Zimbabwe	Training and Research Support Centre
11. Franceso Guaraldi	Italy	University of Modena
12. Edgar Mutasa	Zimbabwe	Training and Research Support Centre
13. Katri Kontio	Finland	University of Helsinki

9.2. Appendix two: Community participant list-Goromonzi District

NAME	WARD	Community group/organization
1. Tendayi Mudyiwa	Gutu	Health worker-Environmental Health technician-Kowoyo Clinic
2. Evengelista Mtewu	Gutu	Health Workers-Sister in charge-Kowoyo Clinic
3. Lilian Nhira	Gutu	Community working group on Health
4. Epifania Nyamusoka	Mwanza	support group
5. Emidio Guni	Mozambique	University of Eduardo Mondhlane
6. Fortunate Machingura	Zimbabwe	Training and Research Support Centre
7. Gelly Musonza	Mwanza	Support group
8. Mable chigora	Chikwaka	Community working group on Health
9. Lauren Gozho	Mwanza	Island Hospice
10. Sincewell Gutsa	Mwanza	Health centre committee member
11. Sarudzai Ndamba	Mwanza	Village Health worker
12. Tariro Njenda	Chikwaka	Shearly Cripps Children's home
13. Success Mutemanenyundo	Chikwaka	Shearly Cripps Children's home
14. Priviledge Chizororo	Chikwaka	Shearly Cripps Children's home
15. Sr Plaxedes Munatei	Mwanza/Chikwaka	St Johns Mission
16. Thabo Seleke	Botswana	University of Botswana
17. Bryan Ngwenya	Mwanza	Shearly Cripps Children's home
18. Kenneth Matengu	Namibia	University of Namibia
19. Anthony Maya	Mwanza	Shearly Cripps Children's home
20. McDonald Kufankomwe	Malawi	REACH Trust
21. Zhoya Marizeni	Mwanza	Home Based Care Giver
22. Guveya Peter	Mwanza	Community member
23. Chirimba Marshal	Mwanza	Community member
24. Love Masanjala	Malawi	University of Malawi
25. Davison Viano	Mwanza	Ministry of Health and Child Welfare
26. Owen Tunha	Rusike	Ministry of Health and child Welfare
27. Moses Mungadzo	Mwanza	Ministry of Health and Child Welfare
28. Esther Sharara	Zimbabwe	Training and Research Support Centre
29. Franceso Guaraldi	Italy	University of Modena
30. Edgar Mutasa	Zimbabwe	Training and Research Support Centre
31. T. Maobvera	Mwanza	Shearly Cripps Children's home- Administrator
32. Augustine Magunyane	Mwanza	Home Based Care Giver
33. Ishe/Chief Chihuri	Mwanza	Ministry of Local Government-Kraal Head-Chief
34. Mrs Chihuri	Mwanza	Ministry of Local Government-Kraal Head
35. Anna Takaendesa	Mwanza	Health centre committee
36. Ms Kaseke	Gutu	Community working group on Health

9.3. Appendix three: Training Programme

Participatory Reflection and Action (PRA) methods for community based systems in HIV treatment
 "Strengthening PRA skills for African and European Research teams in qualitative research"



An ACP-EU co-operation programme in the field of science and technology
 Training and Research Support Centre (TARSC) with
 Community Based Systems in HIV Treatment (CoBaSys) research teams
 Delegates Programme 22-24 April 2010
 Harare, Zimbabwe



EVENING – WEDNESDAY, 21st APRIL

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
700PM	Logistics and planning meeting	Distribution of the PRA protocol	Fortunate Machingura

DAY ONE – THURSDAY 22nd APRIL

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
0800-0830hrs	Registration		
830-0900hrs	Introductions and welcome	Delegate introduction Clear outline of workshop objectives	Fortunate Machingura
INTRODUCTION TO TARSC AND to PRA METHODS for CoBaSys Research			
0900hrs-0930hrs	About TARSC and work on PRA	<ul style="list-style-type: none"> About TARSC: What we do; Our PRA work in ESA 	Barbra Kaim
0930hrs-1000hrs	Understanding the PRA protocol for CoBaSys PRA meetings	<ul style="list-style-type: none"> Brief introduction to the COBASYS PRA protocol and approach to PRA research Critical steps in PRA research The outline of the CoBaSys PRA protocol, 	Fortunate Machingura
100hrs-1030hrs	Tea		
1030hrs-1130hrs	Researching using participatory approaches – -What do we mean by PRA	<ul style="list-style-type: none"> What do we mean by participatory methods Guided discussion on PRA How this is important for research and how results can be used to inform effective sustainable change for human development What PRA skills WILL you learn in this course? What will you NOT learn in this course? How can you learn further? Why PRA is an ongoing learning... 	Senele Dhlomo Barbra Kaim
ACTIVITY GUIDELINES FOR PRA MEETING ONE			
1130hrs-1145hrs	Introduction to community PRA meeting one	<ul style="list-style-type: none"> The outline of community PRA meeting one objectives of PRA meeting one outline of PRA meeting one 	Fortunate Machingura
1145hrs-1215hrs	How can I describe my community with a map	Social mapping and interviewing the map <ul style="list-style-type: none"> Ask what people understand by community, social groups Social mapping and interviewing the map Our understanding of 'community', 'social mapping' How do we document data from the social mapping exercise and data from interviewing the map exercise for this research 	Barbra Kaim
1215hrs-1300hrs	What are the priority health issues in our community?	Ranking and scoring for priority needs Reflection questions after the activity What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have? Are there further questions that communities should be asked	Fortunate Machingura
1300hrs-1400hrs	Lunch		
1400hrs-1500hrs	Identifying causes of priority health needs Identifying actions for these causes	Problem tree and action areas for communities (target populations) Reflection questions after the activity What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have? <ul style="list-style-type: none"> Are there further questions that communities should be asked 	Senele Dhlomo
1500hrs-1600hrs	Identifying the nature of HIV in the community in terms of availability, accessibility, acceptability and contact coverage and discuss the nature of the responses needed for key social groups.	Stepwise diagram and focus group discussion Identify how communities understand effective coverage, contact coverage, acceptability, accessibility and availability coverage Understanding the Tanahashi model Reflection questions after the activity What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have? <ul style="list-style-type: none"> Are there further questions that communities should be asked 	Fortunate Machingura
1600hrs-1630hrs	Tea		
1600hrs-1730hrs	Systems and mechanisms	Market place and focus Group Discussion	Fortunate

	for Referral care	<ul style="list-style-type: none"> Ask participants their understanding for referral care link with key definitions in the protocol Reflection questions after the activity What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have?	Machingura Senele Dhlomo
1730hrs-1740hrs		<ul style="list-style-type: none"> Housekeeping and logistics 	Senele Dhlomo
0830hr-0900hrs	Recap and Reflection	Summarize lessons from day one	Fortunate Machingura

DAY TWO-FRIDAY 23 APRIL 2010

ACTIVITY GUIDELINES FOR PRA MEETING TWO			
0900hrs-0915hrs	Introduction to community PRA meeting two	<ul style="list-style-type: none"> The outline of community PRA meeting one objectives of PRA meeting one outline of PRA meeting one Feedback to communities and how they will be involved in subsequent processes. 	Senele Dhlomo
0915hrs-1000hrs	Linking actions to providers	institutional/ stakeholder analysis Reflection questions after the activity What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have?	Barbara Kaim
100hrs-1030hrs	Tea		
1030hrs-1100hrs	The role of stakeholders in HIV treatment-	Community roundtable discussion <ul style="list-style-type: none"> Follow the activity guidelines as in the PRA protocol At the end ask partners. What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have?	Fortunate Machingura
1100hrs-1230hrs	understanding determinants of HIV treatment systems at primary care level -Defining patient centred health systems particularly on HIV treatment systems	Leaping blocks Ask participants what they understand by people centred health systems Reflection questions after the activity What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have?	Senele Dhlomo
1230hrs-1315hrs	communication between patients and Health workers)-	Margolis Wheel and Spider Web Reflection questions after the activity What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have?	Barbara Kaim
1315hrs-1415hrs	Lunch		
1415hrs-1515hrs	Planning for next steps	<ul style="list-style-type: none"> Have participants understood What is the objective of this tool?; How do you usually get such information? ; Is this something you can do in your own country for CoBaSys research; How do we document such data for the purposes of this research; What difficulties will you have?; What questions do you have? Agree on the items from each activity that will define the feedback/reporting structure Agree on feedback timelines and how reporting to TARSC will be done 	Fortunate Machingura
1515hrs-145hrs	Planning for community meeting	<ul style="list-style-type: none"> Each facilitator will have a role to facilitate and participate in PRA meeting in Goromonzi for practical training on the 24th of April 2010 	Senele Dhlomo
1545hrs-1600hrs	Closing and thanks		Fortunate Machingura