

Mpumalanga Health Policy and
Systems Learning Platform

Community Health Workers Community Mobilisation TRAINING MANUAL

Verbal Autopsy with Participatory
Action Research (VAPAR)



November 2022



health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA





Mpumalanga Health Policy
and Systems Learning
Platform

Community Health WorkersCommunity Mobilisation

TRAINING MANUAL

*The Mpumalanga Health Policy and Systems Learning Platform addresses exclusion from access to health systems by connecting service users and providers to generate and act on research evidence of practical, local relevance.

The platform has been developed through the research programme VAPAR (Verbal Autopsy with Participatory Action Research) progressed by the MRC/Wits Agincourt Rural Health and Health Transitions Research Unit.

MRC Wits/Agincourt hosts the Health and Socio-demographic Surveillance System (HDSS) within which we develop health statistics, using verbal autopsy, and work with local communities to expand local knowledge on health priorities.



Licensed under the Creative Commons License Attribution 2.5

<http://creativecommons.org/licenses/by-nc-nd/2.5>

Please feel free to copy or distribute to anyone you think would benefit. If you're interested in more information on community participation and rapid participatory research methods, visit our website at www.vapar.org and let us know your thoughts.

Warm regards,

VAPAR team



FOREWORD

“The manual, from the department’s perspective, particularly at the sub-district level, inspires a great sense of pride about the realisation of the possibility of building capacity for this cadre of emerging health care workers in SA. The manual will go a long in providing a practical and a formal tool to guide Community Health Workers through their day to day work with communities.”

Mr R Mabika

Acting sub-district PHC manager:
Bushbuckridge

“Nkatsakanyo lowu wa matirhelo (Manual), wu tisa kuti nyungubyisa loku kulu swinene eka Ndzawulo ya Rihanyu, ngopfu-ngopfu eka xifundzha-ntsong xa Bushbuckridge, hikuva wu tisa ku humelela hitlhelo ro antswisa vutivi byo tirha eka ntlawa lowu wa vatirhi va swarihanyu va Ma-Community Health Workers eAfrika-Dzonga. Nkatsakanyo lowu wa matirhelo wuta pfuna swinene ku letela Ma- CHW’s hita matirhelo ya siku na siku eka miganga leyi vatirhaka na yona.”

Mr R Mabika

Acting sub-district PHC manager:
Bushbuckridge



INTRODUCTION

WHAT IS THIS MANUAL?

This manual contains a set of tools that can be used by Community Health Workers (CHWs) who are working in their designated area as part of Ward Based Primary Healthcare Outreach Teams (WBPHCBOTs). The manual aims to assist CHWs to convene community stakeholder groups, to raise and/or respond to priority health concerns, to understand the nature of the concerns from different perspectives in the community and to start a discussion on and facilitate and monitor action that can be taken in communities and in the health systems and public services more widely. CHW are the first line of contact between communities and the health system and are therefore ideally placed to facilitate community engagement, in support of existing governance structures directing contact between the health system and communities, such as district health councils and clinic and community health centre committees, including representatives of communities.

WHO WILL BENEFIT?

The information in this manual has been developed to support CHWs to effectively conduct community mobilisation activities. The process is also intended to benefit people in communities. The tools can be used to support communities to convene to understand and address priority health issues collectively, and to support how the government makes decisions on health care in the local area.

HOW DOES IT WORK?

The manual contains a series of 5 participatory research (PR) tools* to identify, understand and address priority health concerns in rural communities. The tools work through a stepwise sequence to: (1) identify the priority health concern; (2) collect data on the issue; (3) understand the causes and consequences of the issue; (4) map the main actors and impacts involved with the issue; (5) plan action with different stakeholders. 4 of the 5 tools are accompanied by a community-based workshop and the manual provides a discussion guide for each workshop.

The tools are underpinned by a four main principles (described in more detail on page 8):

1. **'homogenous group'** – groups convene with shared conditions and concerns;
2. **'subjective perspectives'** – to understand people's individual experiences;
3. **'collective validation'** – only those issues that the group recognises are registered;
4. **'no delegation'** – those dealing with the issue are the primary actors in the process. The content and messages are aligned with the National Department of Health policies and training curriculum for CHWs.

WHAT ARE WE AIMING FOR?

The process has been designed to promote local action on the social determinants of health, to support the development of mutual understanding and trust relationships between communities and CHWs, and to enable attention to the role of CHWs and WBPHCBOTs in local health governance structures such as clinic committees and district health management teams.

*Adapted from https://equinetafrica.org/sites/default/files/uploads/documents/PAR_Methods_Reader2014_for_web.pdf



CONTENTS

GENERAL

Definitions

Principles

Recruiting participants

Convening stakeholders

Ground rules

Facilitation

IDENTIFYING HEALTH CONCERNS

Tool 1: RANKING AND SCORING

This workshop and tool will enable CHWs and community stakeholders to identify priority health topics of relevance to the community. A list of health priorities is developed during the discussion, after which scoring is applied to identify the health priority of highest relevance at local level. The scoring progresses through at least two rounds with discussion and agreement at the end.

UNDERSTANDING THE ISSUES

Tool 2: PROBLEM TREE

This workshop and tool will enable CHWs and community stakeholders to understand and 'unpack' health priorities identified through ranking and scoring, from different perspectives. Through facilitated discussions using a tree diagram visible to all, participants identify cause-and-effect relationships at various levels, building individual opinions into shared accounts of the issue through consensus.

COLLECTING AND ANALYSING VISUAL DATA

Tool 3: PHOTOVOICE

This tool will enable CHWs and community stakeholders to visually convey lived experience through recording visual evidence of the health priority and validate the evidence from tools 1 and 2. Participants are provided with basic training in photography, to take photographs, with verbal consent, illustrating the topic or condition as it exists in the physical environments. Photographs are presented and discussed in meetings, and captions collectively developed to describe what images convey in relation to the health priority and related causes.

MAPPING ACTORS AND IMPACTS

Tool 4: VENN DIAGRAM

This workshop and tool will enable CHWs and community stakeholders to understand impacts and actors relevant to the cause and / or addressing of the health priority. Collective accounts of relationships and interactions between various actors and institutions are developed, identifying internal and external organisations relevant to the identified local health priority and how they relate to one another in terms of influence, contact and collaboration.

CHANGE PATHWAYS

Tool 5: ACTION PATHWAY

This workshop and tool will enable CHWs and community stakeholders to articulate overall goal(s) to address the health priorities, causes and stakeholder roles identified and visualise and depict stepwise actions and actors to achieve these. The action pathway is collectively developed to represent moving towards a desired goal via a series of interconnected steps and events.

NEXT STEPS

GIVING THE VOICE TEETH

Developing trust relationships with communities

Connecting to district health systems, primary health care (PHC) planning and review
Developing multisectoral engagement and action supporting responses addressing social determinants



GENERAL: DEFINITIONS

COMMUNITY

A group of people living in the same place or having a particular characteristic in common. Communities are dynamic, and always changing e.g. HIV community, LGBTQI community

COMMUNITY MOBILISATION

Community mobilisation can be defined as a process whereby local groups are assisted in clarifying and expressing their needs and objectives and in taking collective action to attempt to meet them. It emphasises the involvement of the people themselves in determining and meeting their own needs. It is closely linked with the concept of participation.

COMMUNITY HEALTH WORKER

Refers to any worker who is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They support the power of community members to make informed choices about their health and wellbeing and provide ongoing care and support to individuals and families who are vulnerable due to disadvantaged situations and at greater risk of acute and chronic illness.

CONTEXT

The social and cultural forces that shape people's everyday experiences and that directly and indirectly affect health and behaviour. These include historical, political, legal structures and processes (e.g. migration), organizations and institutions (e.g. schools, clinics, and community), and individual and personal factors (e.g. family, interpersonal relationships). Notably, these forces are formed in relation to and by each other and often influence people in ways of which they are not consciously aware.

STAKEHOLDER

The terms 'participants' and 'stakeholders' are used inter-changeably in this manual. These refer to people who have influence in the process, or who will become involved during the process.

COMMUNITY PARTICIPATION IN HEALTH

Meaningful participation requires that individuals are entitled to participate in the decisions that directly affect them, including in the design, implementation, and monitoring of health interventions. In practice, meaningful participation may take on a number of different forms, including informing people with balanced, objective information; enabling communities to organise, present and engage with their own lived experience and evidence; consulting the community to gain feedback from the affected population; involving or working directly with communities;

collaborating by partnering with affected communities in each aspect of decision making including the development of alternatives and identification of solutions; and empowering communities to retain ultimate control over the key decisions that affect their wellbeing. Also referred to as community engagement, community involvement and community empowerment.

EMPOWERMENT

To support the power of communities. As a process, empowerment develops capacities in individuals, groups and communities to make purposive choices and to transform those choices into desired actions and outcomes. As a transformational approach, it takes into account the felt needs of the actors and encourages collective involvement.

SOCIAL DETERMINANTS OF HEALTH

The non-medical factors that influence health outcomes. These are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. Examples include: Income and social protection (grants); education; housing, basic amenities, the environment, unemployment and job insecurity and food insecurity..



WHAT IS COMMUNITY MOBILISATION?



health

Department:
Health
REPUBLIC OF SOUTH AFRICA





PRINCIPLES

HOMOGENOUS GROUP

Group with shared conditions, interests, and concerns

The tools in the guide should be used with homogenous groups. By this we mean groups with shared conditions, interests, and concerns, and groups whose voices are often excluded from the processes of service organisation and delivery. The groups that are convened by CHWs should aim to represent a particular view on a particular issue e.g. youth and adolescents and people who are experts in the field such as those delivering services to this group could be convened to discuss alcohol and drug abuse, while a more mixed group of community members (traditional leaders, family members, women of reproductive age) could be convened to discuss an issue such as lack of clean safe water in the community.

SUBJECTIVE PERSPECTIVES

People's individual opinions and experiences are central

People's individual opinions and experiences are very important. Through the different tools you will learn in this manual, people's individual experiences are drawn into the discussions, and arranged into collective forms of knowledge that represent the view of the community on the issue and on actions that might be feasible to address it.

COLLECTIVE VALIDATION

Only those issues that are recognised by group are registered

The process brings people's individual views, opinions and experiences together, and through respectful dialogue arranges these into collective forms of knowledge. A principle to ensure that the collective form of knowledge represents the view of the group is that only those issues that are recognised by the group as a whole are captured.

NO DELEGATION

Those dealing with the issue are the primary actors generating information

Community mobilisation is about the active involvement of those most directly affected by the issue. Therefore, those dealing with the issue are the primary actors generating information on the issue, and discussing and assessing feasible actions that can be taken to address it.

Adapted from: https://equinetafrica.org/sites/default/files/uploads/documents/PAR_Methods_Reader2014_for_web.pdf



GROUND RULES

The facilitator should set out these ground rules to help ensure that the discussions are respectful, and through this work to build mutual understanding and trust relationships between all those involved.

PEOPLE MATTER

People are the foundation of the process. Develop an environment that conveys the idea that people are valued. Consider the physical spaces of meetings. Are they convenient for participants? Do they offer space to have often difficult conversations? E.g. remove broken chairs or equipment.

NON- THREATENING

Offer genuine appreciation of people's views and roles in the community. Acknowledge the value of diverse views, cultures and identities, and encourage consideration of how diverse views can be respected as well as the power of collective action.

NO BLAME

Make sure that people's concerns and frustrations are heard. Acknowledge that there are difficult relationships within communities and between communities and the authorities, but that with time, patience, and respectful dialogue, common aims can be developed through which relationships and trust can grow.

RELAXED ENVIRONMENT

Offer encouragement for people to share experiences and explore solutions.

RESPECT

It is important that there is time and space for listening with respect and interest, and without interruption. Everyone will have a chance to talk and give input. Participants can be asked, for example, to raise their hands before talking to help the facilitator ensure there is balanced input from participants.

INFORMATION

Working in a way that respects the experiences of participants. Bringing different sources of data, including statistical and visual to the process.

DEMANDS ON FACILITATORS

The demands on facilitators, and for resilience on the part of convenors to be part of the conversation on building relationships is critical and key elements of relationship-building. This is a demanding process and the requirements and impacts of that need to be discussed and addressed.



RECRUITING PARTICIPANTS

RECRUITMENT PROCEDURE

CHWs can recruit potential participants using a range of strategies such as door-to-door outreach, or community presentation and activities. During recruitment, CHWs give a brief description of the process, highlighting the aims and objectives of the process. It is very important to ask potential for participants their contact details and address for follow-up and further communication.

As part of this training program, CHWs must recruit potential participants from their communities, possibly that have been involved in some activities in the community, are at home most of the time and are likely to be interested in the priority health topic identified and chosen / voted for during the first workshop. Once you have chosen potential participants, notify them about the time and venue of the workshop and check with them that they are able to get to the venue. Discuss matters of transport reimbursement and an honorarium for participation prior to the first workshop.

Prospective participants should be provided with written information on the process, the objectives and what is involved, with details of any risks and benefits from participating. It is also good practice to give prospective participants enough time (usually around 72 hours) to read and absorb the information and the opportunity to ask questions before agreeing to be involved.

EXAMPLE INVITATION LETTER

An example invitation letter is included. A copy of this letter....

Introduction: Hello, my name is _____ . I'm from the [name] clinic.

Background: We worked in the area in to learn about what people know about different health conditions and what kind of health services can help to respond to the needs of this community. We want to continue and extend these partnerships to support this community to become more involved in activities and decisions that affect health and health services here. To do this, we are forming a Village-Based Discussion group in this village. The group will be made up of community members (e.g., village health workers, traditional healers, women of reproductive age, family members, village leaders etc.). We would like to invite you to be a member of the group for this village.

Involvement: Group members will be invited to a series of meetings. The meetings will each take about 1.5 hours and will be held in this village. At the meetings we will talk about health conditions that are relevant here. We will talk about why people died and how, what it is like to have specific health problems in this community. We will also identify what kind of health services could help with the health needs of people here. This will be useful information for community members and help the Department of Health to improve community and health services, and for village based discussion groups to reflect on and learn from the process relative to any actions taken on the basis of it by the health authority or other groups. We will also provide digital cameras to photograph local areas to inform the discussions and illustrate the issues.

Voluntariness, Benefits & Risks: Whether you choose to be involved is up to you. There will be no effect on you or your family. We anticipate that your input will help decisions to be made about how health services are delivered in the future. There is no risk to your health from being in the process. Talking about death and loss can be difficult. We understand that it might make you feel sad or uncomfortable to talk about these things. If the discussions are upsetting or we can stop the discussion or meeting at any time. If you agree to participate, you will also be free to leave the study at any point and for any reason.

Remuneration & Transport Costs: You will be reimbursed for your travel for coming to the meetings. We will also provide refreshments during the discussions. Participants also receive a certificate of participation at the end (or when you decide to leave the study- if you choose to).

Confidentiality and anonymity: In the reports we may quote parts of the discussion to describe the community's views. Because of this, we cannot guarantee that the conversations will be kept confidential. However, we can guarantee that all the discussions will be private and we will make sure that no-one can be identified in any documents. In the meetings, we will invite you to talk about your opinions and experiences. The information you give is up to you and the meetings will be private. Only those people involved in the process will know whether you are involved. Your identity will not be told to any unauthorized persons; and the discussions will only be shared with people involved in the process. Because the discussions will be in a group, we are not able to ensure the confidentiality of the discussions, but will encourage other participants not to share the identities of other participants with those outside the group. Any information on your identity will be removed before we prepare the reports. Any information that could identify you (name, address etc.) will not be recorded.



CONVENING STAKEHOLDERS

FREQUENCY OF MEETINGS

The tools in this guide are intended to be applied in a sequence of weekly meetings. It is important to acknowledge that a series of at least 5 fortnightly meetings lasting from 2-3 hours is a significant undertaking for both CHWs and community stakeholders. The series and sequence of meetings should be arranged jointly with participants (CHWs and community stakeholders).

NUMBERS OF STAKEHOLDERS

A suitable number for a group discussion is around 12 to a maximum of 16 participants. Depending on the topics identified as of relevance to communities, participants will be agreed in meetings. Prospective participants will be approached according to the topic to facilitate local ownership and relevance.

INFORMATION

Community stakeholders should be contacted individually by phone or in person, and the proposed activities and intended outputs described. Those who express interest can be provided with an invitation letter if possible and given a minimum of 72 hours to think about whether they want to participate, and ask questions by telephone or personally for clarification. For those agreeing to be involved, a convenient time/date will be arranged for the workshops. It is very important that participants agree to be part of the process, and that they understand what the process involves.

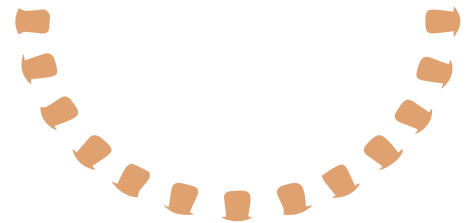
EXPECTATIONS

As community stakeholders are invited

into a process of community mobilisation, it is important to be transparent and honest about activities, time commitments and to be realistic about change that will occur as a result of the process. There is a need to acknowledge (a) discouragement in communities, who may feel that existing health and engagement strategies have not been entirely effective, and (b) challenges and constraints in the system and services especially with regard to resourcing and top down norms/practices.

Figure 1. Seating participants in a large semicircle supports learning and self-reflection

Figure courtesy of: JHPIEGO, 2020





FACILITATION

ACTIVE LISTENING

Active listening is a basic skill for facilitating group discussions. Active listening helps people feel that they are being understood as well as heard, and encourages people to share their experiences, thoughts, and feelings more openly. It shows participants that their ideas are valuable and important when it comes to solving problems. Active listening involves:

- Pay attention: Use body language to show interest and understanding. In many cultures, this will include nodding your head and turning your body to face the person who is speaking.
- Show that you're listening: Showing interest and understanding to reflect what others are saying. It may include looking directly at the person who is speaking. In some communities, such direct eye contact may not be appropriate until the speaker and the listener have established some trust. Listen not only to what is said, but also to how it is said, by paying attention to the speaker's body language.
- Ask clarifying questions: Asking the speaker questions to show that you want to understand. "Can you explain how you can this this conclusion?" "Where did you hear that?" Summing up the discussion to check that what was said was understood. Ask for feedback.
- No judgement: Remind yourself that a conversation doesn't have to be about you or the other person joining sides or agreeing. Allow the speaker to finish their point before asking clarifying questions.

FACILITATION DO'S AND DON'T'S

It is advisable to have two facilitators in each workshop. Following each workshop, the facilitators should dedicate time for collective reflection on what worked well, what didn't and how to improve.

DO

- Be confident
- Use silence and be comfortable with it
- Ask open (not closed, requiring only 'yes' or 'no' responses) questions to ensure participation
- Invite participation of the quieter members of the group
- Use your intuition and trust your gut feeling to guide you in the direction to take
- Maintain control

DON'T

- Pretend you understand when you do not
- Dominate
- Give advice
- Use your organisational or community position / standing to give you power
- Use the group as therapy for your problems
- Be judgemental
- Talk too much

USEFUL FACILITATION TIPS

- Contact each person before the workshop starts
- Use the word 'AND' instead of 'BUT'. E.g. you've said....AND it sounds like Robert disagrees with you
- Ask more questions
- Listen, reflect, and empathise
- Make individual contact during the session
- Acknowledge everyone's opinions
- Establish group expectations and agreements up front.



IDENTIFYING HEALTH CONCERNS

TOOL 1: RANKING AND SCORING

WORKSHOP GUIDE

INTRODUCTION

The meeting should be 2-3 hours. There needs to be an attendance register, the register is very important for final report writing.

This is a community mobilisation process to build community knowledge and action around the social and structural determinants of health. The process is also to build trust and find solutions along with health and local authorities.

GROUND RULES

Our environment is non-threatening, no-blame and democratic. Everyone here is an official member and a partner in the process. Read/discuss the 4 principles (page 8). Together we are a team. Here, we will begin to organise experiences, identify shared needs and desired outcomes.

OUTLINE PROCESS AND ACTIVITIES

- We would like to meet once per week, every second week for 5 weeks in meetings of 2-3 hours at a time
- People can leave at any time and for any reason
- We will ask about people's experiences and opinions on the topic nominated
- From this we will develop collective understandings and actions to address the issues identified
- We will take the outputs of the process, with community representatives, to engage with stakeholders in the district health system to analyse, plan and act on the information that we generate.

- We will repeat the process to reflect on, and learn from, any actions taken

WORKSHOP OBJECTIVES

- To agree on the venue and time for next workshops
- To identify and prioritise health concerns/topics within the community
- To agree on the target population relevant to the priority topic/expanded group (codesign)
- To identify skills acquired during the workshop
- Produce a short summary report of the workshop

CHOOSING THE TOPIC

- Follow process in Tool 1
- Ask another CHW to be in the workshop and to write down important discussion points

CO-DESIGN THE PROCESS

- Does this group represent this community? Who is missing? Can we bring them in? What does this mean for our findings? What do we do about this?
- Define community as people who share defined conditions, here in the village or local area / a geographical location
- We would like to work with other

groups that represent people who are socially disadvantaged, e.g. young single mothers? What is your advice on this?

- Can we think about what this means for including new participants. Who do we include in the future?
- Discuss and agree inclusion criteria for new group members - record
- When would the meetings be most convenient?
- Who might benefit from this process? Who owns and controls it?

READING AND VERIFICATION OF GROUP RECORD AND THEN GROUP REFLECTION

FINAL QUESTIONS AND FEEDBACK - DATE/TIME FOR NEXT MEETING



TOOL 1: RANKING AND SCORING

To identify priority health topics of relevance to the community. A list of health priorities is developed during the discussion, after which participants apply scoring in order to identify the topics of highest relevance, using adhesive stickers, beans or sticks. The scoring progresses through at least two rounds with discussion and agreement at the end.

METHOD:

ranking and scoring/multi-dot system

TIME:

30 mins

MATERIAL:

pen and flip chart paper, counters (stones, seeds, markers)

OVERVIEW

This tool will enable CHWs to identify priority health topics of relevance to the community. A list of health priorities is developed during the discussion, after which participants identify the topics of highest relevance using beans, counters or adhesive stickers. The scoring progresses through two (or more if necessary) rounds with discussion and agreement at the end.

PROCEDURE

1. Ask participants to list health/social needs/concerns in their community. They can do this on the flip chart, this can be at the front of the group or on the ground. If the group is diverse, from different social groups with different levels of power and articulation, this discussion can first be facilitated in smaller groups and then together to avoid dominance.

2. When the list has been developed, give each participant 3 stones, beans or any other marker available. Ask them to distribute or place their counters against three health concerns they think are most important and need the greatest attention. If a participant feels strongly about one priority concern, more than one of his / her counters may be placed against one concern. Ask participants to discuss and interrogate the scoring.

Prompts

- What were the differences between the participants' priorities?
 - How can you explain these differences?
 - What do they tell us about the different needs of different stakeholder groups?
 - How does this impact on health programmes?
 - Do these findings reflect the views of everyone in the community? If not, how can you ensure that other community members' views are taken into account?
3. Ask if anyone wants to change their priority topic at this stage and allow them to do so.
4. Count the total counters for each item listed and write the totals on the flip chart paper. The group now has a list of three top priority health concerns which are the three with the most counters. Record these

three on a new flip chart.

5. Ask participants to justify why they thought these three health concerns deserve most attention.

Prompt

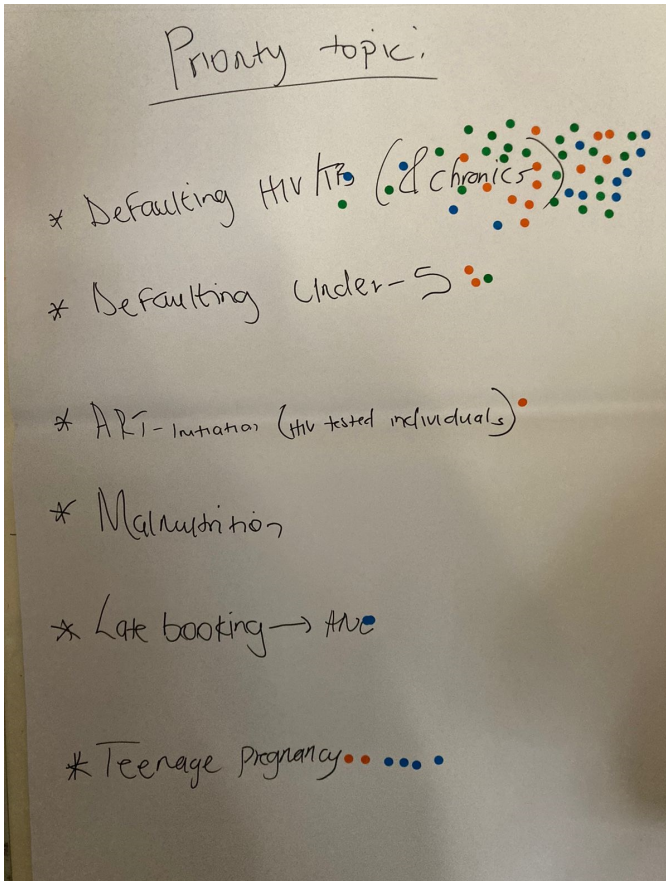
- We now have a list of concerns in the community, which one is the biggest priority among those listed?
6. Have a second round of scoring on the three prioritised concerns so that one health concern is identified.
7. Note and record strong outlier views.
8. Conclude the priority topic and record.

Adapted from: Cavestro, 2003; https://liberiafti.files.wordpress.com/2013/08/cavestro_participatory-rural-appraisal-concepts-methodologies-techniques.pdf

Loewenson et al, 2006 https://www.equinet africa.org/sites/default/files/uploads/documents/EQUINET_PRA_toolkit_for_web.pdf



EXAMPLE: RANKING AND SCORING





WORKSHOP REPORT A) GROUP RECORD

	<p>The person who has been recording the most important discussions fills in this record. Facilitator takes digital images of the flip charts with ranking/scoring/multi-dot system. The recorder records queries, comments or areas of debate raised in the discussion below. The scribe reads this record at the end of the session and one of the other participants verifies.</p>
<p>Session recorded by:</p> <p>Verified by*:</p>	
<p>1. Purpose and participants</p>	
<p>2. Process and activities (roles and reporting)</p>	
<p>3. Priority health concerns (see Tool 1)</p>	
<p>4. Expanding the process (communities, locations)</p>	
<p>Queries, concerns, areas of debate raised</p>	

* Participant who confirms that the content of this form is a true reflection of the group discussion



WORKSHOP REPORT B) GROUP REFLECTIONS

	CHW asks another participant in the group to ask these questions and the CHW records the group answers
Session recorded by:	
Verified by*:	
1. What are the main lessons and skills you learned in this workshop?	
2. How will you use the skills obtained in this workshop in future?	
3. What challenges did you experience in this workshop?	
4. Who benefits from this process?	
5. What would you change about the workshops?	
6. Are these skills that you can transfer to other CHWs? What support would you need to do so?	
7. Did the workshop meet the objectives?	

* Participant who confirms that the content of this form is a true reflection of the group discussion



ORGANISING EXPERIENCES

Tool 2: PROBLEM TREE

WORKSHOP 2: GUIDE

INTRODUCTION

The workshop should be 2-3 hours. Facilitators take digital images of discussion and participants. There needs to be an attendance register, the register is very important for final report writing.

GROUND RULES

Our environment is non-threatening, no-blame and democratic. Everyone here is an official member and a partner in the process. Read/discuss PAR Principles from Handout (page 8). Together we are a team. Here, we will begin to organise experiences, identify shared needs and desired outcomes.

WORKSHOP OBJECTIVES

- To develop an understanding of the causes and impact of concern
- To identify needs and desired outcomes for [health concern]
- To identify skills acquired during the workshop
- Produce a short summary report of the workshop

OUTLINE PROCESS AND ACTIVITIES

Our focus is on developing knowledge on priorities. Revisit priority concern identified. Participants invited to draw on their knowledge/experience of the

priority health concern. Record discussion (see prompts) and confirm record with group in Group Record.

ORGANISING INTO COLLECTIVE KNOWLEDGE

- Follow process in **Tool 2**
- Record discussion and confirm record with group

SUMMARY AND REFLECTIONS

- Now we have finished the discussion, Mr/s [NAME] will summarise our discussion to the group.
- Is this an accurate summary? Did we miss anything?
- What about the activities? Should any changes be made? What works? What doesn't?
- Who benefits from this process? How? Who controls the process? How?
- Invite feedback on the process. What do people think about participation?

READING AND VERIFICATION OF GROUP RECORD AND THEN GROUP REFLECTION

FINAL QUESTIONS AND FEEDBACK - DATE/TIME FOR NEXT MEETING



TOOL 2: PROBLEM TREE

INTRODUCTION

This is a tool to understand and ‘unpack’ nominated topics from different perspectives. Through facilitated discussions using a tree diagram visible to all, participants identify cause-and-effect relationships at various levels from root (tree roots) to intermediary causes (trunk and branches) and consequences and other effects (tree pods), building subjective perspectives into shared accounts through consensus.

Method:

Problem tree (organising causes)

Time:

45mins

Materials:

Copy of the ‘problem tree’/ask participants to draw

OBJECTIVE

Understand the major causes and consequences of health concern(s).
Develop shared understandings of the health concern(s).

PROCEDURE

This activity helps participants to explore the root causes of an identified health concern. The problem tree offers a structured way of getting to the various levels of a problem.

FOCUS ON PRIORITY HEALTH CONCERN

Facilitator invites input and makes list of issues related to [CONCERN] and records them on a flipchart.

Prompts

- What is known about [concern] and its causes?
- What are the experiences of people in this group?
- What are signs/symptoms and interventions
- How do services respond?
- Is there a shared definition? How has this concern had an impact in this group? In the community?
- Who is affected? Does [concern] affect different groups in different ways? How?

The list is interrogated and discussed, participants cross-check and discuss with each other; [Facilitator takes care to maximise the diversity and richness of information, and to check, verify, amend and added to the collective account and ensure that the participants own it]; [Facilitator encourages inputs from all participants to organise the list].

ANALYSE PROBLEM

Using a picture of a tree, participants analyse the causes of the identified problem. The pods are the problems; The branches that hold them are the immediate individual or biological causes; The large branches are the environmental causes; The trunks or roots are the underlying structural causes; The ground is the political systems and values that are the context for the structural causes. Facilitator records each point on the tree once the group has decided where it goes on the tree.

LOOK AT THE CAUSES AND DISCUSS

During this discussion, the position of the points on the tree might change, and the facilitator can make these changes on the problem tree diagram.

Prompts:

- Which causes can communities act on with the resources they have? How?
- Which ones need to be acted on by others within their own district or area?
- Who do communities need to influence to make these actions happen?
- Which ones need to be acted on by governments or other national institutions?
- Who do communities need to influence for these actions?

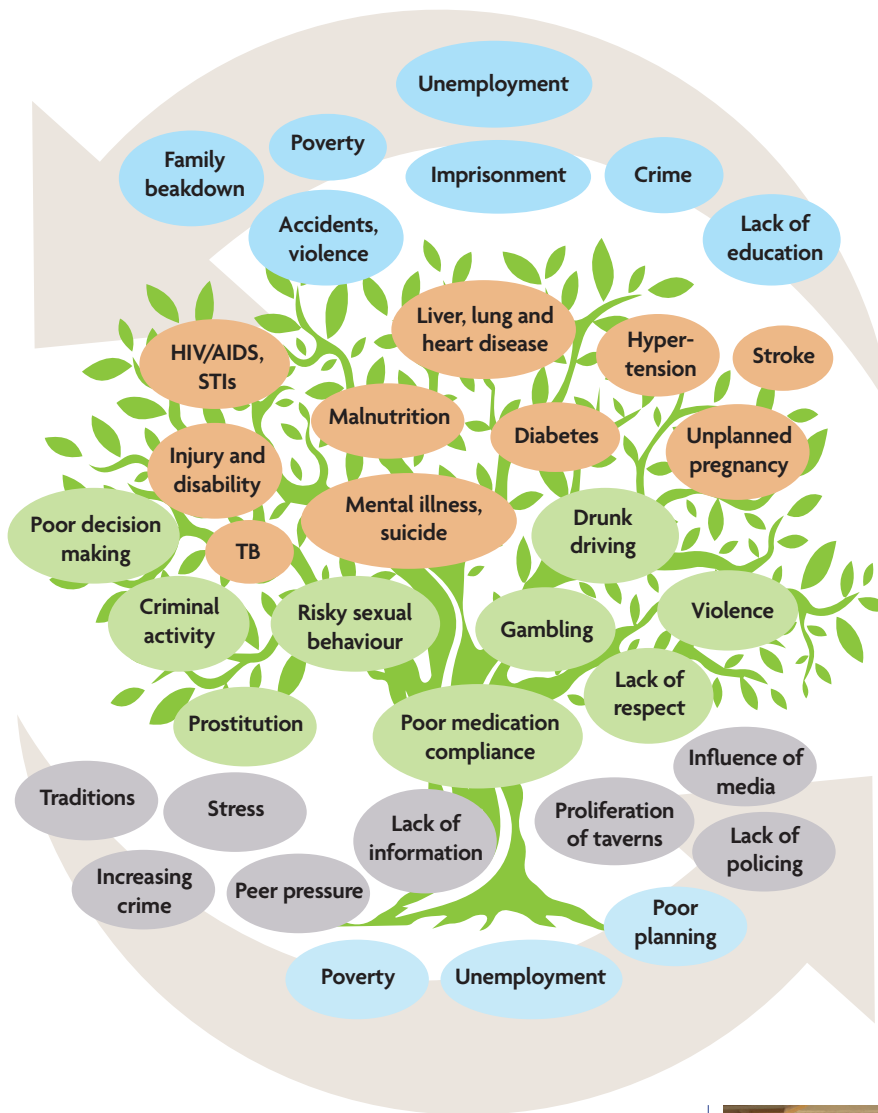
RECORD

Record on the session record sheet (see overleaf). Facilitator takes digital images of the diagrams. Facilitator records queries, comments or areas of debate raised in the discussion

Adapted from: Cavestro, 2003 https://liberiafti.files.wordpress.com/2013/08/cavestro_participatory-rural-appraisal-concepts-methodologies-techniques.pdf

Loewenson et al, 2006 https://www.equinet africa.org/sites/default/files/uploads/documents/EQUINET_PRA_toolkit_for_web.pdf

EXAMPLE: ALCOHOL AND DRUG ABUSE



CHW u byela u n'wana wa va ngheneleri eka ntlawa leswaku a vutisa swivutisoleswi kutani CHW a tsala ti nhlamulo leti ti vuriweke hi ntlawa.
Social impacts

1. Hi yihi dyondzo na swikili leswi u swi dyondzeke eka workshop leyi?
2. U ta yi tirhisa njani dyondzo leyi u yi kumeke e ka workshop leyi eka mundzuku?

Health impacts

3. Hi yini mintlhonthlo leyi u hlangeke na yona eka workshop leyi?
4. I va mani va vuyeriwaka hi maendlelo lawa?

Behavioural impacts

5. I yini lexi u nga xi ncincaka hi ti workshop leti?
6. Leswi ku ngava ku ri swilo leswi u na swi dyondzisaka va n'wana?

Mediating processes

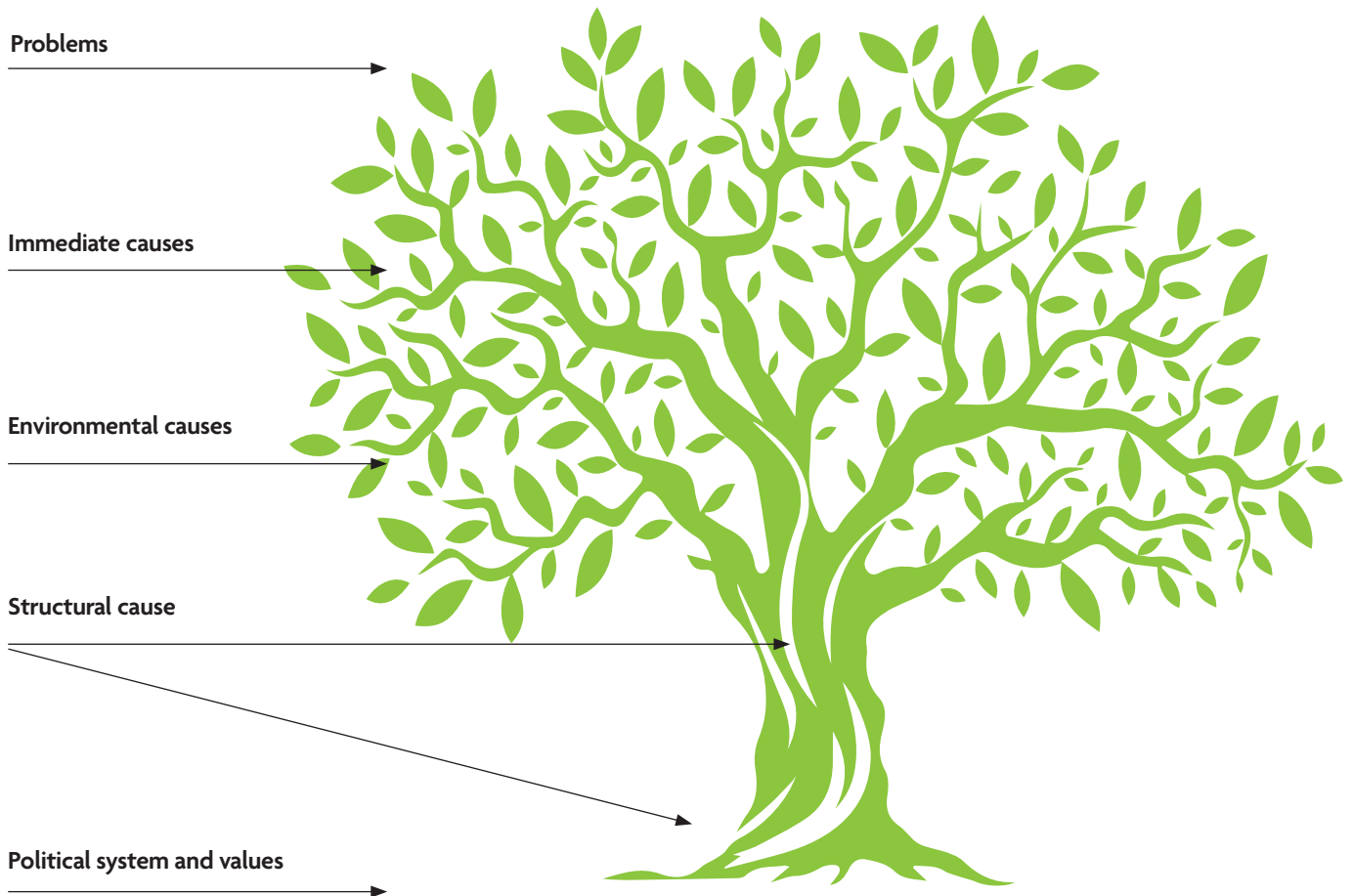
7. Workshop yi ngava yi fikelerile nkongomelo wa yona?

Root causes





PROBLEM TREE TEMPLATE



Source: https://www.equinet africa.org/sites/default/files/uploads/documents/EQUINET_PRA_toolkit_for_web.pdf



WORKSHOP REPORT A) GROUP RECORD

	<p>The person who has been recording the most important discussions fills in this record. Facilitator takes digital images of the flip charts with ranking/scoring/multi-dot system. The recorder records queries, comments or areas of debate raised in the discussion below. This process may be continued following the workshop. The scribe keeps record of all discussions and reads this record at the start of the next workshops and one of the other participants verifies.</p>
Session recorded by:	
Verified by*:	
1. List words/ features/ experiences to describe [topic]	
2. Suggested shared definition of [topic]	
3. Impacts of topic in this group (preliminary)	
4. Main needs and desired outcomes around [topic]	

* Participant who confirms that the content of this form is a true reflection of the group discussion



WORKSHOP REPORT B) GROUP REFLECTIONS

	CHW asks another participant in the group to ask these questions and the CHW records the group answers
Session recorded by:	
Verified by*:	
1. What are the main lessons and skills you learned in this workshop?	
2. How will you use the skills obtained in this workshop in future?	
3. What challenges did you experience in this workshop?	
4. Who benefits from this process?	
5. What would you change about the workshops?	
6. Are these skills that you can transfer to other CHWs? What support would you need to do so?	
7. Did the workshop meet the objectives stated in the beginning?	

* Participant who confirms that the content of this form is a true reflection of the group discussion



COLLECTING VISUAL DATA

TOOL 3: PHOTOVOICE

This tool can be applied where resources and time allow to visually convey lived experience. Participants given basic training in photography, ethics and digital cameras or using smart phones to take photographs illustrating the topic or condition as it existed in the physical environments. Photographs presented and discussed in meetings, and captions developed to describe what images conveyed.

METHOD:

Photovoice

TIME:

30 mins

MATERIAL:

digital cameras or smart phones, notepads and pens

OVERVIEW

To visually convey lived experience. Participants given basic training in photography, digital cameras or smart phones to take photographs illustrating the topic or condition as it existed in the physical environments. Photographs presented and discussed in meetings, and captions developed to describe what images convey

WHAT IS PHOTOVOICE?

Photovoice is a method that helps those who are often the subject of photographs to become photographers and tell their own story. Photovoice believes nobody should be denied the right to speak out and be heard.

BASICS OF PHOTOGRAPHY

Photography is “drawing with light”. Stakeholders can be introduced to: (a) composition/framing: ask participants to make a rectangle with thumbs and forefingers of both hands. Held to the eye, this forms a viewfinder which can be moved in/out by moving arms forwards/backwards; (b) Foreground and background – what is the relationship between them? (c) The main subject or focal point – where should it be placed in the frame? (d) Cropping within the frame – do you want to include all of the main subject? (e) The basic shapes in the picture / Creating space between objects. Proximity or distance from the main subject.

USING YOUR PHONE TO TAKE AND SEND PROFESSIONAL PICTURES

Open discussion about who has access to email, WhatsApp or other online communication methods and discuss how to send pictures with verbal permission from people in them from the phone to other devices.

EXERCISES

Stakeholders asked to go in pairs to take 3 pictures and return to the group in 15 mins to present and discuss. The pictures can be of landscapes, people/portraits, emotions, movement etc. Return to the group to discuss the pictures taken. Take notes about the images and write a few words about the photograph, who took the photograph, what it is of, why they took it, and what it is intended to communicate.

SOME GROUND RULES

Participants need explain to subjects why they are taking photographs and what the intended use of these photos might be; **ALWAYS ASK PERMISSION BEFORE TAKING SOMEONE'S PHOTOGRAPH.** They should acquire written consent wherever possible. If not possible, verbal consent should be acquired before a photograph is taken of another person. Everyone is entitled to privacy and to be made aware of what they are being associated with.

Further ethical guidance for the use of Photovoice is available it: <https://photovoice.org/wp-content/uploads/2017/05/Ethical-Statement.pdf>

VISUAL EVIDENCE

Community stakeholder presenting and discussing visual evidence (image reproduced with permission)

“By presenting and discussing visual evidence that is collected throughout the process, community stakeholders build skills in public speaking and analysis, group work and relationship building”



EXAMPLES: VISUAL EVIDENCE

Examples of visual evidence on alcohol and drug abuse, with captions developed by community stakeholders

ALCOHOL AND DRUGS - THE STRESS RELIEVERS

Men dancing and singing after drinking alcohol and smoking. Alcohol and drugs were described as stress relievers for people living in hardship. According to participants, alcohol makes them forget their problems and helps them through to the next day.



Photographer: Delight Zitha / VAPAR learning platform

YOUTH DRINKING AND DRIVING

A young man (face hidden for anonymity) at the wheel of a car at night with an alcoholic drink in one hand and a cell phone in the other. Villagers considered such practices as contributing to the high levels of death and disability owing to road traffic accidents in the village



Photographer: Cornright Zitha / VAPAR learning platform

ALCOHOL ABUSE IN OLDER PEOPLE

An elderly woman (face hidden for anonymity) lies down after drinking a number of bottles of beer. The photo was taken in the early hours of the day to show how widely alcohol use and abuse is accepted in the community: it is normal for anyone to drink alcohol at any time of day

Source: Mabetha, 2018



Photographer: Ennie Khoza / VAPAR learning platform



MAPPING ACTORS AND IMPACTS

TOOL 4: VENN DIAGRAM

WORKSHOP GUIDE

INTRODUCTION

The meeting should be 2-3 hours. Facilitators take digital images of discussion and participants. If participants have one photo they want to share with others, then this should be shared across devices. Today we want to build our understanding of the impact of the health concern.

GROUND RULES

Our environment is non-threatening, no-blame and democratic. Everyone here is an official member and a partner in the process. Read/discuss PAR Principles from Handout (page 8). Together we are a team. Here, we will begin to organise experiences, identify shared needs and desired outcomes.

WORKSHOP OBJECTIVES

- To identify services for addressing needs for [health concern]
- Understand impacts and identify gaps/weaknesses to be addressed or strengths to be reinforced
- To share any photographs that participants wish to illustrate
- To identify skills acquired during the workshop
- Produce a short summary report of the workshop

OUTLINE PROCESS AND ACTIVITIES

Facilitator displays the problem tree. We have developed a collective account of [health concern]. Today we will build our understanding of [concern].

ADDRESSING THE ISSUES DISCUSSED

- Follow Tool 4: Venn diagram

SHARING PHOTOS

Each participant to share one photo with participants and discuss.

SUMMARY AND REFLECTIONS

- Now we have finished the discussion, Mr/s [NAME] will summarise our discussion to the group.
- Is this an accurate summary? Did we miss anything?
- What does this mean for who and how [health concern] is experienced?
- What does this mean for health planning, services and health workers?

READING AND VERIFICATION OF GROUP RECORD AND THEN GROUP REFLECTION

FINAL QUESTIONS AND FEEDBACK - DATE/TIME FOR NEXT MEETING



TOOL 4: VENN DIAGRAM

This is a tool to understand impacts and actors involved. Collective account developed with Venn diagram made from cardboard circles of different sizes and colours to indicate relationships and interactions between various actors and institutions, identifying internal and external organisations active in the topic and how they related to one another in terms of contact and collaboration. Identify services (health and other) for addressing needs for [health concern]. Identify how services perform in relation to desired outcomes, access, uptake

Method:

Venn diagram (Stakeholder mapping)

Time:

45mins

Materials:

large piece of paper, small coloured pieces of paper, scissors

Background:

Venn Diagram shows institutions, organisations, groups and important individuals in the village, as well as the villagers' view of their importance in the community. Additionally, the Venn Diagram explains who participates in these groups in terms of gender and wealth. The Venn Diagram also indicates contact and cooperation between those organisations and groups.

OBJECTIVES

- To identify organisations/groups/ persons active in the community around [specify local area, identified priority health concern]
- To identify who participates in local organisations/institutions
- To find out how different groups relate to each other in terms of contact, co-operation, flow of information and provision of services

PROCEDURE

1. Working in groups, participants list the main health-related institutions operating in their community.

Prompts

- Ask participants which organisations/ institutions/ groups are found in the village and which other ones from elsewhere are working with them or have an influence on them.
 - Make sure that they also think of the small not formal groups like e.g. neighbourhood committees.
2. Write the names of these institutions and people on the flip chart.
 3. Provide participants with paper circles of different sizes to represent each institution/person, the larger circle, the more important the institution/person.
 4. Ask the participants to compare the sizes of the circles and to adjust them so that the sizes of the circles represent the importance

of the institution, organisation or group. Participants should write the organisation name of the size of paper the group decides best represents the organisation. More actors may be identified at this time and should be added to the list and allocated a circle.

Prompts:

- What kind of ways of assisting each other for [health concern] exist among people?
 - Which local groups are organised?
 - Are there political groups?
 - Who makes important decisions in the village?
 - Are there local people working/ concerned with politics, livestock etc? Who are they and how do they contribute?
5. Ask participants to place the circles on a bigger piece of paper showing their relationships and linkages – the overlaps indicate cooperation between or among institutions and separate circles show no links or that the roles or activities of the institutions are different. Participants can adjust the size or arrangements of the circles as they consider appropriate.

Prompts:

- Why is this institution so far away from the others?
- These 2 institutions are overlapping – what type of activities do they share?
- Document what they say.

* Participant who confirms that the content of this form is a true reflection of the group discussion

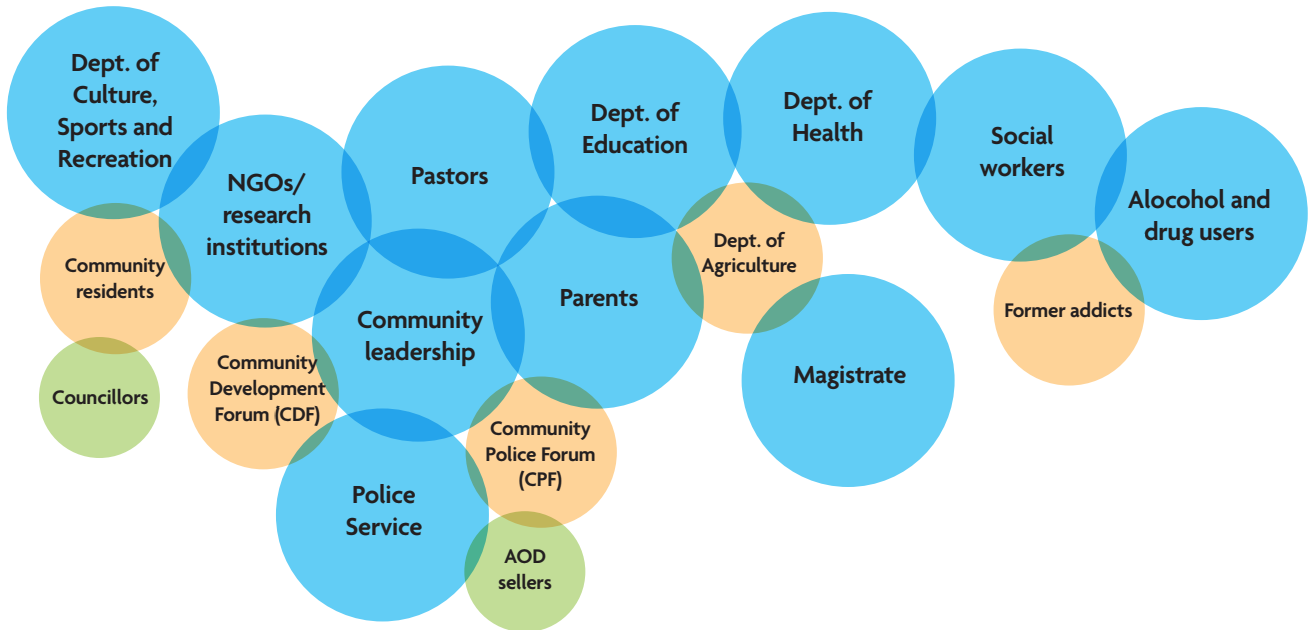


6. At the end, exhibit the diagram and do all or some of the following
 - Identify patterns in the way institutions relate to each other
 - Look at whether certain people, for example, women, the unemployed, migrants or orphans etc, are excluded from participation in certain institutions. Suggest reasons why they are not represented and how they cope.

Record on the session record sheet (see overleaf). Facilitator takes a photo of the diagrams. Facilitator records queries, comments or areas of debate raised in the discussion, or asks another CHW to help with taking these notes and images.

Adapted from: Cavestro, 2003;
Loewenson et al, 2006 https://liberiafti.files.wordpress.com/2013/08/cavestro_participatory-rural-appraisal-concepts-methodologies-techniques.pdf

EXAMPLE: ALCOHOL AND DRUG ABUSE



Key

- Most important actors/institutions
- Important actors/institutions
- Less important actors/institutions



Source: Oladeinde et al, 2020



WORKSHOP REPORT A) GROUP RECORD

	<p>The person who has been recording the most important discussions fills in this record Facilitator takes digital images of the flip charts with ranking/scoring/multi-dot system. The scribe records queries, comments or areas of debate raised in the discussion below. This process may be continued following the workshop. The scribe keeps record of all discussions and reads this record at the start of the next workshops and one of the other participants verifies.</p>
<p>Session recorded by: Verified by*:</p>	
<p>1. Impact of this topic in the group (build in preliminary)</p>	
<p>2. Suggested shared definition of impacts</p>	
<p>3. Needs: identify priority gaps/ weaknesses to be addressed and strengths to be reinforced</p>	
<p>4. Main actors who can address these</p>	

* Participant who confirms that the content of this form is a true reflection of the group discussion



WORKSHOP REPORT B) GROUP REFLECTIONS

	CHW asks another participant in the group to ask these questions and the CHW records the group answers
Session recorded by:	
Verified by*:	
1. What are the main lessons and skills you learned in this workshop?	
2. How will you use the skills obtained in this workshop in future?	
3. What challenges did you experience in this workshop?	
4. Who benefits from this process?	
5. What would you change about the workshops?	
6. Are these skills that you can transfer to other CHWs? What support would you need to do so?	
7. Did the workshop meet the objectives stated in the beginning?	

* Participant who confirms that the content of this form is a true reflection of the group discussion



CHANGE PATHWAYS

TOOL 5: ACTION PATHWAY

WORKSHOP GUIDE

INTRODUCTION

The meeting should be 2-3 hours. We have developed a problem tree and a Venn diagram from previous workshops, today we will develop a change pathway and action plan from this group to address the issues identified.

GROUND RULES

Our environment is non-threatening, no-blame and democratic. Everyone here is an official member and a partner in the process. Read/discuss PAR Principles from Handout (page 8). Together we are a team. Here, we will begin to organise experiences, identify shared needs and desired outcomes.

WORKSHOP OBJECTIVES

- To develop a and action pathway from this group to address the issues identified
- To share any photographs that participants wish to illustrate
- To identify skills acquired during the workshop
- Produce a short summary report of the workshop

OUTLINE PROCESS AND ACTIVITIES

Facilitator displays problem tree and Venn diagram from the previous meetings. Facilitator revisits the main features, needs and desired outcomes around [concern] from the problem tree. Facilitator revisits the main actors, institutions and services (health and other) from the Venn diagram. From these activities we will now consider actions to address the issues identified.

PRIORITISING ACTIONS

- Follow Tool 5: Action Pathways
- Actions are listed and ranked.

SHARING PHOTOS

Participants to share one photo with participants and discuss.

SUMMARY AND REFLECTIONS

- Now we have finished the discussion, Mr/s [NAME] will summarise our discussion to the group.
- Is this an accurate summary? Did we miss anything?
- What does this mean for who and how [health topic] is experienced?
- What does this mean for health planning, services and health workers?

READING AND VERIFICATION OF GROUP RECORD AND THEN GROUP REFLECTION

FINAL QUESTIONS AND FEEDBACK - DATE/TIME FOR NEXT MEETING



TOOL 5: ACTION PATHWAYS

This is a tool to articulate overall goal(s) to address the issues identified and visualise and depict stepwise actions and actors to achieve these. The action pathway was collectively developed to represent moving towards a desired goal via a series of interconnected steps and events

Method:

Action pathways (ranking and scoring/ multi-dot system)

Time:

45mins

Materials:

pen, flip chart, counters (stones, seeds, adhesive markers)

PROCEDURE

This activity is about thinking through processes to bring about a long-term, future goal – identifying and addressing assumptions people hold about change and enabling logic to be captured and communicated in an easy-to-read diagram.

OBJECTIVES

- Review Problem Tree and assign actions to actors in Venn Diagram
- Develop action pathways

PROCEDURE

1. Ask participants to list possible actions in their community and wider services, with reference to the Problem Tree and Venn diagram. They can do this on the flip chart, this can be at the front of the group or on the ground.

Prompts

- Which causes can communities act on with the resources they have? How?
 - Which ones need to be acted on by others within their own district or area?
 - Who do communities need to influence to make these actions happen?
 - Which ones need to be acted on by governments or other national institutions?
 - Who do communities need to influence for these actions?
 - When can these actions take place?
 - How can we monitor them?
 - How will we know then they have been achieved?
 - What is the role of DoH? What is the voice of this community?
2. When the lists have been developed, give each participant 3 stones, beans or any other marker available. Ask them to distribute or place their counters against three actions they think are most important and need the greatest attention. Ask participants to discuss and interrogate the scoring. Have a second round of voting: Count the total counters for each item listed and write the totals on the flip chart paper. The group now has a list of top priority health actions. Record these on a new flip chart.
 3. Ask participants to justify why they thought the top actions deserve most attention.

4. Action pathway: Talk through the pathway - a series of actions leading towards the long-term outcome in the future. Leave the sample action pathway diagram visible on a flipchart for reference.
 - Provide group with flipchart paper, pens, and pieces of A5 paper with the words “action, actor, when and monitored” written on them (see example on the next page).
 - Write actions (actors, when and how to monitor) from the earlier step onto the pieces of A5 paper that they can move around in their groups until they agree on a action pathway.
 - Make it clear that it is not essential to come up with a ‘perfect’ action pathway diagram (and they may even choose not to include all the actions identified in the earlier session).
 - When they have settled on the action pathway, ask them to draw in the arrows between actions and outcomes.

Prompts

- What is the ultimate outcome? Is this realistic?
- How do the actions in the sticky notes contribute to achieving this outcome?
- Can we cluster some of these actions together?
- What are the processes/ pathways?
- Can we agree an action pathway and action plan?
- Interrogate the arrows, how does this action lead to the next one?



- How can we monitor them?
- How will we know then they have been achieved?

Monitoring action is an important component of participatory methods and tools, in order to build learning from action and strategic review.

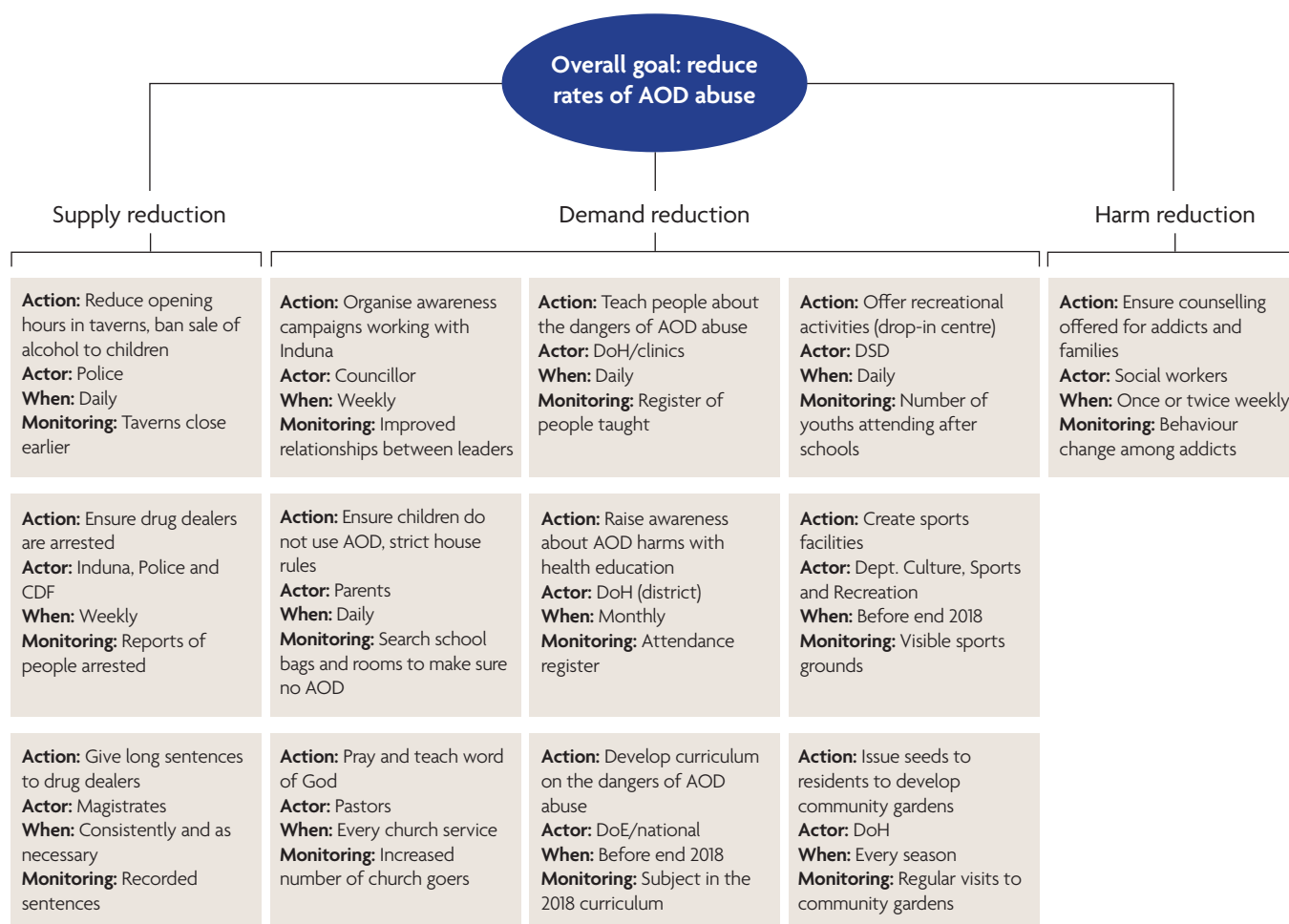
Further information can be found here:

<https://www.tarsc.org/publications/documents/MCV%20Implementers%20Resource%202021%20for%20web.pdf>

5. Conclude the priority actions and record

Adapted from: Cavestro, 2003; Loewenson et al, 2006; Convention of Wetlands (1971). A Guide to Participatory Action Planning and Techniques for Facilitating Groups

EXAMPLES: ACTION PATHWAYS



Source: Oladeinde et al, 2020



* Participant who confirms that the content of this form is a true reflection of the group discussion



WORKSHOP REPORT A) GROUP RECORD

		The person who has been recording the most important discussions fills in this record Facilitator takes digital images of the flip charts with ranking/scoring/multi-dot system. The scribe records queries, comments or areas of debate raised in the discussion below. . This process may be continued following the workshop. The scribe keeps record of all discussions and reads this record at the start of the next workshops and one of the other participants verifies.	
Session recorded by:			
Verified by*:			
1. What are the main features, needs and desired outcomes around [topic]			
2. What are the actions required, how can these be achieved, by who and when?			
3. Can we organise these actions?			
How	Who	When	Monitoring

* Participant who confirms that the content of this form is a true reflection of the group discussion



WORKSHOP REPORT B) GROUP REFLECTIONS

	CHW asks another participant in the group to ask these questions and the CHW records the group answers
Session recorded by: Verified by*:	
1. What are the main lessons and skills you learned in this workshop?	
2. How will you use the skills obtained in this workshop in future?	
3. What challenges did you experience in this workshop?	
4. Who benefits from this process?	
5. What would you change about the workshops?	
6. Are these skills that you can transfer to other CHWs? What support would you need to do so?	
7. Did the workshop meet the objectives stated in the beginning?	



NEXT STEPS: GIVING COMMUNITY VOICE TEETH

NEXT STEPS

Some of the main challenges reported by CHWs in their role is lack of trust between them and the communities, and lack of resources. Although CHWs serve a critical purpose in communities, they are often only known as providing HIV related services and awareness of other services is low.

DEVELOPING TRUST RELATIONSHIPS IN COMMUNITIES

Regular, respectful engagement and meaningful communication is essential to build mutual understanding as a foundation for trust relationships between CHWs and communities. Many people in rural communities are not aware of spaces such as the community feedback meetings, leadership meetings and other spaces where various stakeholders meet to engage on issues affecting local people. There are several ways to raise community voice and support the use of evidence generated through rapid participatory methods.

CONNECTING TO RESEARCHERS

VAPAR is embedded in the MRC/Wits-Agincourt Unit's Health and socio-demographic surveillance system, which brings additional data to bear on the effects of the community-nominated priorities. VAPAR researchers support spaces and processes enabling engagement, exchange and the aligning of external research to national and sub-national priorities and needs to facilitate the accountability of researchers to local contexts, and the uptake of research output and the meaningful translation of research into policy and practice.

MULTISECTORAL STAKEHOLDERS

Developing multisectoral engagement and action supporting community responses addressing social determinants can be achieved by engaging stakeholders in the process set out in this manual. Stakeholders can be invited to join from provincial and district DoH including PHC, MCHWYN, HAST and NCD programmes. As can representatives from the Department of Cooperative Governance and Traditional Affairs (COGTA), Department for Social Development (DSD), Department of Basic Education (DBE) and Department of Culture, Sport and Recreation (DCSR). Key local

stakeholders include clinic committee, ward committee, Local Municipality and the sub-district.

CONNECTING TO THE HEALTH SYSTEM

Supporting routine PHC planning and review with evidence on community-nominated public health priorities, associated burdens of disease, the lived experience of that burden, and on how and with whom action could progress to address the issues identified is fundamental to the process. Prior to e.g. clinic committee meetings, sub-district PHC review meetings, or district health management team (DHMT) meetings, community groups supported by CHWs can plan for engagement, including convening smaller sub units planning and review teams, and negotiating access to programmes (e.g., maternal, child, women's and youth health), and convene sub-sets of management groups to support with priority setting, review and feedback as appropriate.



REFERENCE LIST

Cavestro L (2003) Participatory rural appraisal concepts, methodologies and techniques

https://liberiafti.files.wordpress.com/2013/08/cavestro_participatory-rural-appraisal-concepts-methodologies-techniques.pdf

Cleary S, du Toit, A, Scott V, Gilson L (2018) Enabling relational leadership in primary healthcare settings: lessons from the DIALHS collaboration. *Health Policy and Planning*, 33: ii65-ii74.

https://researchonline.lshtm.ac.uk/id/eprint/4648712/1/Cleary_etal_2018_Enabling_relational_leadership.pdf

Convention on Wetlands (2008) A guide to participatory action planning and techniques for facilitating groups. Ramsar CEPA.

<https://www.yumpu.com/en/document/read/25662605/a-guide-to-participatory-action-planning-and-techniques-ramsar->

JHPIEGO (2020) Gender-transformative leadership: a participatory toolkit for health workers, facilitator guide. JHPIEGO, Maryland, USA.

<https://www.jhpiego.org/wp-content/uploads/2020/07/GTL-Full-Toolkit.pdf>

Loewenson R, Kaim B, Mbuyita S, Makemba A (2006). Organizing people's power for health: participatory methods for a people centred health system, EQUINET, Harare, Zimbabwe.

https://www.equinetafrica.org/sites/default/files/uploads/documents/EQUINET_PRA_toolkit_for_web.pdf

Loewenson R, Laurell AC, Hogstedt C, D'Ambruso L, Shroff Z (2014) Participatory action research in health systems: a methods reader/ TARSC, AHPSR, WHO, IDRC Canada, EQUINET, Harare, Zimbabwe.

https://equinetafrica.org/sites/default/files/uploads/documents/PAR_Methods_Reader2014_for_web.pdf

Loewenson R, Simpson S, Dudding R, Obando F, Beznec P (2021) Making change visible: evaluating evidence to advance social participation in health, an implementer's resource. TARSC.

<https://www.tarsc.org/publications/documents/MCV%20Implementers%20Resource%202021%20for%20web.pdf>

Oladeinde O, Mabetha D, Twine R, Hove J, Van der Merwe M, Byass P, Witter S, Kahn K, D'Ambruso L (2020) Building cooperative learning to address alcohol and other drug abuse in Mpumalanga, South Africa: a participatory action research process. *Global Health Action*, 13:1, 1726722.

<https://www.tandfonline.com/doi/full/10.1080/16549716.2020.1726722>

Photovoice (2015)

<https://photovoice.org/>



WWW.VAPAR.ORG

This program is supported by the Health Systems Research Initiative from Department for International Development (DFID)/ Medical Research Council (MRC)/ Wellcome Trust/ Economic and Social Research Council (ESRC) (MR/N005597/1, MR/P014844/1) and with support from the University of Aberdeen Grand Challenges Research Fund (GCRF), Scottish Funding Council (SFC). The work is a collaboration between the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt), School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, Directorate for Maternal, Child, Women and Youth Health and Nutrition, Mpumalanga Department of Health, South Africa, Queen Margaret University, Edinburgh, Scotland UK and the University of Aberdeen, Scotland UK

Permissions have been secured for the reproduction of all images





WWW.VAPAR.ORG

Mpumalanga Health Policy and Systems Learning Platform

**Community Health Workers
Community Mobilisation
TRAINING MANUAL**

Verbal Autopsy with Participatory Action Research (VAPAR)