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INSTITUTE OF DEVELOPMENT STUDIES

*MEMORANDUM*

**To:** Participation Group

**Date:** 20 October, 1997

**From:** Robert Chambers

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**DfID Health Meeting**

I was asked to make a presentation on October 8th to a meeting of DfID health people at their annual meeting. Attached is roughly what I tried to say - FYI.

D:Health

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## WHOSE REALITY COUNTS?

### PARTICIPATORY APPROACHES TO ASSESSING THE REALITIES OF POOR PEOPLE AND MONITORING THEIR BENEFITS FROM HEALTH SERVICES

A background note for October 7th

A **quiet methodological revolution** is taking place. We now have to hand a range of popular and powerful participatory approaches, methods and behaviours (as e.g. in PRA\*), many of which were not known or had not come together a decade ago. Participatory approaches and methods have shown a potential for empowering communities, and those who are weaker within them, especially women. These approaches and methods, when well facilitated, can enable poor and marginalised people to express, analyse and share their realities and priorities. These often differ from what we as professionals had earlier recognised or supposed. To the question "Whose reality counts?" it is now possible to answer: it can be "theirs" much more than before.

A **new professionalism** then opens up, to enable those who are poor and marginalised to be better off according to their own realities and priorities. This requires changes in the dominant behaviour and attitudes of outsiders, shifting from a teaching mode to one of facilitation. Modern medical knowledge remains powerful and vital, but the starting point in the community is "their" knowledge and analysis of their conditions, experiences and priorities. For development professionals this presents enormous opportunities.

Is the key **participatory behaviour and attitudes**? If so, are health professionals disadvantaged by the superiority of much of their knowledge, for example of the microscopic? Does the vital importance of health to poor people give health professionals exceptional power which is then a disability? Consultations with poor people have revealed again and again how the arrogant or unfriendly behaviour of health staff upsets and deters poor people who need treatment. Is it more difficult for health professionals than, say, their colleagues in agriculture, to sit down, listen, facilitate, learn and empower local people, and to respect their knowledge, analysis and priorities? If so, is there then a huge agenda of personal, institutional and professional reorientation, and a huge potential in gains for the poor?

On participation, the draft **White Paper** says (page 29): "**We will encourage participatory approaches which take into account the views and needs of the poor.**" This is a strong statement but in my view (the sound you can hear is an axe grinding) should go further. There is a case for making participatory approaches and methods not just something to be encouraged, but a centre-piece to give the new strategy teeth. The logic and momentum of what is happening will probably put participation in the centre anyway, so it would be best said from the start. It is difficult to see how poverty can be confronted and overcome sustainably in poor countries, unless participation is made a cornerstone.

Already, **Participatory Poverty Assessments (PPAs)**, in countries as diverse as Bangladesh, Ghana, South Africa, Tanzania and Zambia, using participatory methods (especially PRA) have contributed insights for policy and practice. Remarkably, they have shown that for very poor people health is usually a higher priority than education, and have pointed to some of the reasons.

D. Health

**Health and poverty are more closely linked than most development professionals recognise.** For the poor themselves, though, the links are commonplaces of experience. Neglected dimensions include:

- the body as poor people's main, precious and vulnerable asset
- the vulnerability of single-parent households
- the opportunity cost of sickness at times of peak labour
- during the rains, the interlocking seasonalities of sickness, deprivation, debt, the need to be able to work, diminished child care, ineffective and inaccessible health services, and late pregnancy and birth
- the counter-seasonality of statistics and of professionals' visits and perceptions
- sequences of sickness-related impoverishment, especially when breadwinners fall ill, in part through earnings lost but more through expenditures for treatment (especially for breadwinner men), often leading to deep, desperate and irreversible poverty and misery for surviving women

Participatory analyses of poor people's realities and approaches have indicated a **range of health-related priorities**. These include those which are obvious and well known, like access to

- affordable and good treatment
- adequate and effective drugs
- clean and accessible water.

There are also others that may be less obvious such as:

- places for washing in private (<sup>second</sup> ~~top~~ of all doable priorities for poor urban women in Bangladesh)
- all weather roads to give access to treatment in the rains (Zambia and elsewhere)
- training health staff to be friendly, welcoming and polite (almost everywhere)

Participation, and democratic decentralisation point to **local monitoring and management of health services** as a means to better performance. Increasingly, local people are showing that they can identify and monitor their own indicators. To the extent that participatory monitoring and management in health exist more in rhetoric and recommendations than in reality, this is an area for experimentation, action research, and sharing experience. PRA methods have already been used in this context, with many more potential applications.

There is a **synergy** between the renewed focus on poverty in the White Paper, and the new participatory approaches, methods and behaviours. The challenges and opportunities are professional, personal and institutional. When so much is opening up, it is a good time to be alive, and we are lucky to be around and active just now. Well, I think so, and I hope to share with you more of why.

6 October 97

Robert Chambers

\* I shall bring multiple copies of Sources and Contacts, which lists sources of information, and addresses of national and other PRA-related networks

*povheal.doc*