June 2003

Have you been PA'd?

Using Participatory Appraisal to shape local services

East End Health Action

Greater Easterhouse Community Health Project

NHS Greater Glasgow

Oxfam

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Photo: East End Health Action

A PA checklist for the community, organisations and decision-makers

☐ **Identification of aims and objectives** Are the aims of the appraisal clear, relevant and owned by all? Who else should know, be involved, and when?

☐ **Strategy for achieving aims and objectives** Is there a strategy for achieving these aims? Are key decision-makers involved from the beginning and committed to taking forward outcomes of the process?

☐ **Communication about the process** Is there a wide understanding of what the exercise is about and what it aims to achieve?

☐ **Record keeping** How is the information being recorded and documented? Is there a system for ensuring confidentiality and anonymity if necessary? Is there a breakdown of who has been involved – by gender, area, diversity, age, and interests? Are there common recording methods used consistently by all facilitators?

☐ **Time for reflection and analysis** Is there evidence that the process of analysis was iterative? Do the findings correspond with other sources of data?

☐ **'Reaching the parts...'** Are there people in the community who are not involved? Is there a particular group that is dominating? Are women and men equally participating and influencing?

☐ **Tension and conflict** How are issues of conflict and tension being dealt with? Are they ignored, glossed over, avoided?

☐ **Focus on action** Is this just an exercise in gathering problems and "wish lists"? Does the process move towards an action plan? Is there evidence of analysis and prioritisation by the community, rather than general information gathering?

☐ **Don't dump issues** Have other actors been brought in to deal with issues outside the mandate?

☐ **Verification** Is participation in verification activities as inclusive as other parts of the process? Is there a feedback mechanism to the community?

☐ **Maintaining momentum** What is the timeline for the process? Is everyone aware of this? Are a range of tools being used?

☐ **The outcome; report and/or decisions** What plans are there to take actions forward? Or to monitor/evaluate the action plan? Does the written report reflect multiple voices/perspectives? Has it, and other outputs, been widely circulated?

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Foreword

So – why Participatory Appraisal? Do we not already know what the community thinks? Are priorities not well established and it is really just a matter of getting on and delivering?

As chair of the Greater Easterhouse Partnership I believe it is vitally important that partnerships (and the public sector generally) continue to develop new methods of community engagement. Traditional methods, including community involvement structures, thematic approaches with special interest groups, and the establishment of People's Panels (in the case of Greater Easterhouse involving 1,000 local people) are all crucial elements in determining strategies and directing regeneration activity. But it is increasingly recognised that traditional models alone may not be enough. We must be open to fresh approaches that support dialogue with local people.

The studies in this report demonstrate an enthusiasm to try something new. This also involved risks; it was important to recognise that not everything might work first time round, but that innovation must be embraced and supported.

When done well, Participatory Appraisal techniques have shown themselves to be a powerful addition to existing methods of community involvement. They are not a substitute for established community development and engagement process, but rather an important additional means of involving a significant number of people to accurately assess views and priorities. I was particularly struck by the successful participation by senior pupils from Lochend Community High School in the PA team that delivered the programme in Greater Easterhouse. The Young Person's Health project too is to be commended as a further demonstration of Participatory Appraisal techniques being used to effect change in public services.

I suspect that with the increased requirement for community involvement within the emerging arrangements for Community Planning in Scotland, Participatory Appraisal techniques will come into their own. The ability to reach large numbers of people and actively involve residents who may not normally be engaged through traditional methods is incredibly exciting.

The strength of the partnership between Oxfam, NHS Greater Glasgow, The Greater Easterhouse Community Health Project and East End Health Action in delivering the two projects has to be congratulated. In both areas there has been considerable community learning and a positive legacy.

The public sector has much to learn from these processes. Participatory techniques are extremely beneficial in supporting engagement with local communities and I anticipate a more regular use of these methods in future.

I trust you will find this report not only interesting, but of practical benefit when planning policy and considering community engagement opportunities.

Councillor James Coleman

Chair of Greater Easterhouse Social Inclusion Partnership

Executive Summary

"When those unaccustomed to speaking are heard by those unaccustomed to listening then real changes can be made."

Greater Easterhouse Community Health Project

Participatory Appraisal, or PA, as it is known, is a methodology that was originally developed with rural communities overseas (see page 8 for more details on the tools used in PA). It has only recently started being used in the UK. PA methodology is designed to involve people, particularly from communities that are socially excluded, in decisions that affect their lives. The beauty of PA is that the tools can be used with large or small groups, on any topic, and with a wide range of different people, from the grassroots to decision-makers.

When two local community health projects, East End Health Action and Greater Easterhouse Community Health Project, used PA in a series of workshops looking at health issues. Both organisations were excited by the process. The communities involved were also "sold" on PA as a dynamic and participative way of working - ***"Everyone has their say in PA"*** as one enthusiastic participant put it. Together with Oxfam's UK Poverty Programme and the Greater Glasgow NHS Board, they commissioned an evaluation. The purpose of this was to review the experience of the two projects in acquiring the skills and using the technique, so that lessons learned could be shared with other community projects in the area, as well as decision-makers.

In addition to the evaluation, those involved in the project decided that they wanted to produce a practical report.

This report introduces PA, showing what it is (and what it is not) and what it can achieve. Taking examples from the projects themselves, and using the voices of those involved in the processes, it demonstrates how PA can be used in community and agency decision-making. It also shows what was learned by the community, by the organisations involved, and by decision-makers.

It provides those who might be thinking of using PA with a practical guide that takes them through the process from beginning to end. It has an extensive list of organisations and people to contact and a checklist for organisations, communities and decision-makers.

The organisations and people who have produced this report have found that being involved in PA has not only helped with the planning and delivery of projects, but has altered the way that they themselves work.

Greater Easterhouse Community Health Project has always started with the community itself. Because PA is about community involvement, it has slotted neatly into the Project's philosophy: ***"When those unaccustomed to speaking are heard by those unaccustomed to listening, then real changes can be made."***

For East End Health Action staff ***"PA techniques have become part of everyday work practice… PA has become a subconscious attitude,"*** said one development worker.

They hope that this will also be true for other communities throughout the UK.

"PA techniques have become part of everyday work practice… PA has become a subconscious attitude."

Scotland, health and poverty

Scotland has a population of just over five million. The discovery of North Sea oil in the 1970s and the destruction of Scotland's industrial base in the 1980s had huge economic and social consequences. In the 1980s and early 1990s the number of people in Scotland living in relative poverty more than doubled.

- 21% of households with adults of working age have no-one in work
- The proportion of Scottish children being brought up in workless households doubled from 13.7% in 1979 to 26.4% in 1997
- People from the poorest areas in Scotland are now nearly three times as likely to die early than people from the richest areas. Scotland has some of the highest death rates in the world for cancer and heart diseases. Mental illness is increasing.
- Life expectancy at birth in Scotland is two years less than in England and Wales[1]
- 20% of unemployed adults have been unemployed for more than five years
- 52% of households have a net annual household income of £10,000 or less. Two thirds of single parent households have a net annual household income of £10,000 or less[2]
- 50% of all households receiving incomes at or below Income Support level are female-headed[3]
- Over 45% of women have under £100 a week individual income, compared to just over 29% of men[4]
- There is still a pay gap of 17% between women and men[5]

Glasgow itself has some of the highest levels of deprivation in Scotland

- The city contains 78% of Scotland's most deprived areas
- Across the UK as a whole, Glasgow has the second highest rate of households with no earner in the family[6]
- A Glasgow male has a life expectancy of five years less than one in Edinburgh, but someone living in one of Glasgow's affluent areas will have an Edinburgh life expectancy[7]
- The incidence of admission for alcohol related problems is 10 times higher in the poorest sections of the city[8]
- Across Glasgow the level of drug addiction has been found to be six times higher in the poorest communities.

1 The first five statistics are from the Scottish Executive's Social Justice Annual Report 2000

2 The final four are from the Scottish Household Survey 2000

3 Scottish Household Conditions Survey 1997, quoted in the Women's Manifesto for the Scottish Parliamentary elections 2003

4 DSS/Women's Unit/1999:1 quoted in the Women's Manifesto for the Scottish Parliamentary elections 2003

5 Close the Gap campaign, quoted in the Women's Manifesto for the Scottish Parliamentary elections 2003

6 Other material from Church Action on Poverty article by Kathy Galloway, www.church-poverty.org.uk/

7 Regeneration Unit of the Chief Executive's Department, Glasgow City Council

8 Greater Easterhouse SIP Health and Wellbeing section, draft 6

1 Introduction

This report comes from a body of work undertaken in the Glasgow area with people from two local community health projects, East End Health Action and Greater Easterhouse Community Health Project. The projects cover a wide range of issues, but they had three things in common:

1. Both areas had previously been identified as areas of deprivation and as such were part of the Scottish Social Inclusion Partnership (SIP) programme.
2. Both wanted to involve the community in decisions affecting their lives, whether this was about a local play scheme or how to feed into a major healthcare project.
3. In order to do so, and with the help of trainers recruited by Oxfam's UK Poverty Programme, they used what are known as participatory appraisal (PA) tools.

Why consider PA?

Today, there is a demand for public organisations to develop their services around evidence of need. Combined with this is a strategic desire to accumulate this evidence from as many people as possible; people who are representative of the overall population in respect of gender, race, age and life circumstances.

Traditionally, the methods adopted by many organisations to consult communities have included questionnaires, focus groups and large-scale one-off public consultation events.

There is a need for both quantitative and qualitative methodologies, especially when information is required from a diverse range of individual experiences around very focused, and sometimes highly sensitive, subject matters, such as addiction, domestic violence and sexual behaviours.

Participatory Appraisal (PA) provides one qualitative option. Originally developed for use with rural communities overseas, it can effectively engage, identify needs, and agree options for intervention with a wide range of people, from the grassroots to those in charge of decision-making.

However, PA goes beyond just information gathering. Instead it endeavours to create an ongoing relationship over a period of years. This gathers information not only in relation to need, but also in terms of what services should be developed, where they should be located, how they should be designed, how effective they are and what changes would improve their effectiveness.

"PA allows for the interaction between policy-makers from the top, formulating policies and an evidence of knowledge from the bottom (community)", said a member of the SIP Health Strategy panel.

It is also a useful tool for tackling social exclusion, following the SIP rationale that social exclusion comes from not being able to be involved in decision-making. PA is an effective methodology for facilitating the sharing of power – provided decision-makers involved in the process then go away and act on the information they have gathered. When this happens, PA can become a real vehicle for social change.

"PA allows for the interaction between policy-makers from the top, formulating policies and an evidence of knowledge from the bottom (community)."

What are SIPs?

SIPs are multi-agency partnership bodies which include local authorities, health boards, further education providers, the private sector and, crucially, the local community and voluntary sector. There are currently 48 Social Inclusion Partnerships (SIPs) operating, 14 of which are thematic. SIPs are tasked with the coordination of activities to promote social inclusion, prevent social exclusion and develop innovative models of working.

The Scottish Executive has indicated that it expects local communities and the voluntary sector to be at the heart of SIP decision-making processes. In 2002 it launched its Community Regeneration Statement, outlining a commitment to tackling poverty and disadvantage in Scotland and setting out the changes necessary to make this happen.

This is now being run by Communities Scotland, and it is proposed that the management of SIP funding will shortly come under its umbrella. See www.scvo.org.uk/sip

See also www.scotland.gov.uk

"We now know a lot of our rights; PA has opened up other doors for us," said a member of the East End community after being involved in a PA process.

Both projects used the PA methodology to inform the development of their local SIP Health Strategy and Action Plans. The findings have also played a significant role in the SIP development process.

As a result, members of both communities were keen to continue to use PA methods. They also wanted to show other people in similar situations how they had used them, and how useful they had been. This report is an attempt to do just that.

A fight for fulfilment

Greater Easterhouse Community Health Project and East End Health Action

"We now know a lot of our rights; PA has opened up other doors for us."

Greater Easterhouse in Glasgow was built in the 1950s and 60s to re-house slum dwellers from the Gorbals and has a population of 32,000. It is one of the major peripheral housing estates in Glasgow and has experienced many of the social, economic and environmental problems associated with isolated estates. It has 14 separate and distinct communities that vary in terms of population, social and economic characteristics, facilities available and service provision etc.

Greater Easterhouse Community Health Project has been a partner on the SIP Health and Wellbeing programme since its inaugural meeting. During that time the group has been developing a health strategy for the general Easterhouse area. Community involvement is key to all its work – with any issue, it begins by talking to local people and then implements its programmes on the basis of what they say.

The project is involved in the Easterhouse Mental Health Programme, where PA is being used to review the past and look at plans for the future. It also works with the Addictions Forum and the Young People's Health Project (see Case Study 3). The Community Health Project's strategy and objectives spring from a statement pinned up in the project office: "Health is not bought by the chemist's pill nor saved by the surgeon's knife. Health is not only the absence of ills, but the fight for the fulfilment of life."

The East End Social Inclusion Partnership area has a population of 33,000. It also has one of the worst health indicators in Europe and one of the poorest health records in the UK. East End Health Action (EEHA) started life in 1991. Its strategic objectives are to:

- Address inequalities in health within the East End SIP area.
- Empower communities and individuals within the SIP area to clarify and determine their role in improving health.
- Build and maintain effective collaborative partnerships to promote health by encouraging community and organisational participation.
- Develop and evaluate innovative community development approaches to health.

The project is based in Dalmarnock. It is committed to reducing inequalities in health within the East End Social Inclusion Partnership area by supporting community action and effective inter-agency working on health. Some of the areas supported include a child safety project, a healthy living centre, the SIP Health strategy group, a young people's health resource, men's health, an alcohol education and prevention project, and Dalmarnock regeneration working group.

The evaluation

In autumn 2001 an independent researcher evaluated both PA exercises. The aims of this were:

- To provide evidence of the value and worth of the use of PA by both projects.
- To gain an understanding of all stakeholders' personal experiences, views and opinions of the PA exercise.
- To identify gaps and barriers preventing effective delivery of the aims and objectives of the PA exercise.
- To make recommendations on the practicalities of delivering and sustaining future PA exercises.

This publication draws on the results of the evaluation and, combined with the recent thinking of all authors, aims to provide the reader with an introduction to PA theory, an insight into the realities of PA in action within an urban setting and some thoughts for future application.

It should be noted that what follows is not a detailed illustration of the methods employed by PA workers, but an explanation of the processes and impacts of PA on communities, workers and policy-makers alike.

2 What is Participatory Appraisal?

"PA gives the community an opportunity to raise and address local issues and be actively involved in the decision-making process."

John, East End Health Action

Participatory Appraisal is a family of approaches and methods that enable people to present, share and analyse their knowledge, and to allow them to plan and take action from their findings. The basis of the approach is that local people are the experts on their own lives and that their views and priorities should be the starting point for any local planning and action.

Many of the methods are visual, and create opportunities for people to participate in discussions at the level that they are comfortable with. The approach can be used in meetings, with groups or individuals. Sometimes people participate for a few minutes, at other times for an hour or more. The methods can be used wherever people are at home, in the pub, at bus stops, in schools, clubs, at the shopping centre. They are accessible across age, gender and cultural differences.

To ensure that a wide range of views are taken into account, and to reduce any bias, an important aspect of PA is to check out or understand an issue from different points of view. This is done by using the techniques to look at different people's perspectives. In addition, findings and results of any work are checked out or verified with different members of the community.

Where did it come from?

PA was developed by people working in rural development within Third World countries. They were concerned that all too often this development was controlled by outsiders working from their own perceptions of the problems of rural people, and that these perceptions were coloured by many different factors – season, location/access, gender, income, time of day, preconceptions and culture. There was also concern that traditional survey techniques, very often questionnaires, were costly, time consuming and full of their own inherent flaws of bias.

Many of the tools were borrowed from social anthropology and participatory research. PA appeared originally as Participatory Rural Appraisal (PRA), but is referred to with different names depending on who is using/promoting it. People using it in the UK have tended to drop the "Rural" and refer to it as Participatory Appraisal (PA). More recently, the International Institute of Environment and Development (IIED) adopted the name Participatory Learning and Action (PLA), to better describe the family of methods and the contexts in which they are increasingly being used.

The underlying principles of PA

- The need to recognise and work with the knowledge and experience of local people.
- The need for local people to have more say and control in the development process.
- The need to understand the context for different groups and the constraints on people.
- Rapid progressive learning.
- "Optimal ignorance" and "appropriate imprecision" – not finding out more than is needed, and not trying to measure more accurately than needed or what does not need to be measured.

What does it do?

Visual methods – using diagramming to aid analysis and discussion. This has a number of advantages:

- people can represent their own realities in their own terms
- there is a common focal point of reference during a discussion-so the visualisation works whether using words or symbols
- transparency – everyone can see what is being recorded
- ownership – because it is open, it is easier for people to feel in control

"PA isn't just about using Post-it notes; it is a process of involving local people in shaping their community's future."

John, East End Health Action

- accessibility to all; diagramming helps to overcome barriers that often prevent people from engaging in discussion – such as language, literacy skills, lack of confidence, disabilities or sensory impairment.

PA also:

"PA is about asking people and not doing it for them."

- Allows comparisons and relative values to be discussed
- Seeks diversity in opinion and experience
- Encourages groups as well as individuals
- Moves from closed ownership of information by outsiders to public ownership of processes and outputs
- Enables local people to control the process and set their own agendas.

What can it be used for?

"PA is about asking people and not doing it for them."

Health Project Coordinator

PA is very powerful in the planning and implementation of projects – facilitating not only the identification and prioritisation of issues to be addressed, but also deciding what can be done to tackle them, developing action plans and monitoring and evaluating success. It is often used in surveys, appraisals and research. When this happens, it needs to be very clear what the outcome of the process will be and how decisions will be made using the information generated.

What are the tools and techniques?

"It feels safe when you write on the Post-it note. Your comments are anonymous."

Participant at an East End Health Action Workshop

There are many tools and techniques, and the list expands continuously as the tools are added to and adapted by different users.

They include:

Mapping

Maps allow people to represent their environment – to explore what resources in their area are important to them, which are missing, what isn't valued and why. Mapping can be done with individuals and groups, of any age and ability. Basically, people draw sketch maps – either using pen and paper, or using objects to create a three-dimensional map. With a large group of people, maps can be drawn on the floor or the wall, and contain as much information as people want them to. Some mapping techniques, such as mobility maps, don't explore geography, but are used to represent where people go most frequently and for what purpose. See Case Study 2.

Time analysis

How do people's lives change through the day, week, month and year; what has changed in people's lives over many years, or their lifetime – and how would they see it changing in the future? What influences and causes those changes? A range of different tools can be used – 24-hour clocks explore how much time people spend on particular tasks/activities, weekly diaries can explore daily challenges. Calendars can help explore how things change over a year – when are the easy times and when are the difficult ones? Timelines that cover issues over a person's lifetime can explore longer-term issues and are also invaluable when planning action. See Case Study 1.

Linkages and relationships

There are many tools that help analyse cause and effect, the impact of actions and the relationships between people, institutions and actions. Popular tools in this group are the spider diagram – see Case Study 1 – and causal impact analysis – see Case Study 2. Through these tools an issue is explored in depth; the participants are continuously asked to dig deep – why does something happen like this? As each question is answered it is captured, but then "why?" is asked again. In this way, the issue is "taken apart", and this can be captured as branches, or intersecting circles. Getting to "root causes" can also translate visually into root diagrams.

Prioritisation and quantification

Exploring a range of issues in the community is in many ways the easy part; moving towards a collective agreement on priorities and action can

prove difficult when there are different interests.

There are a range of tools that help in teasing out key issues, help define problems, prioritise issues in terms of importance and dimension; and move analysis into action planning. 3-2-1 prioritisation and responsibility matrices were used by East End Health Action in the case studies described in this report. In 3-2-1 prioritisation, options are presented clearly in some way – on flipcharts or as objects – and people are asked to vote on their priorities – first, second and third. This is an open process, and promotes active discussion and negotiation about overall community priorities. Having decided what the community wants to do, the process can move into planning, and again clear frameworks can be used, ensuring questions such as: What needs to be done? Who will do it? When? How? are asked and answered.

How well can a tool from one context be used in another?

On the whole the tools have transferred very well from overseas to the UK:

- Although there are higher levels of literacy here and words are used more often than pictures or symbols, the visualisation is still really important.
- "Handing over the stick", or pen (see page 15 for more details) – ensuring that people are really listening to what is being said, is as important here as it is anywhere else
- Reaching out to the marginalised - those for whom standard ways of working with the community (meetings, questionnaires) are difficult to access
- The need to shift emphasis towards engaging local people in development work is as necessary here as it is elsewhere

What PA is not

PA is not a magic wand that will instantly produce "community empowerment". Using PA won't necessarily result in a sound, inclusive and participative process, and there are many examples of bad PA practice.

As with any other community development approach, it is how it is used that is important. If the underlying principles are respected, it can effectively facilitate a process that could lead to greater empowerment of the community.

There is a guide to achieving good PA practice in section 5.

3. PA in action in an urban setting

In this section we present three very different examples of PA in action. They have been chosen to illustrate:

1. The range of situations in which PA can be used, from action planning to influencing policy
2. The ways in which the different tools were used to facilitate analysis and planning
3. The way PA was used to explore difference within the community.

In the first case study, of Dalmarnock Millennium Play Association, the key impact was the empowerment of young people to plan and implement their own project. PA tools were used by young people from different age groups to facilitate their own process.

The second case study, in the East End Social Inclusion Partnership area, was a series of PA focus groups which gave local people the opportunity to assist in influencing future health policy development for the area. There was a particular focus on territoriality, which previously had not been seen as an issue within health, or as an issue by older people within the community. As a result of the process, the issue of territoriality was included in the SIP Health Strategy document.

The last case study, developing a new health service for young people in Greater Easterhouse, also illustrates how PA is effective in allowing people to identify their own issues and set new agendas.

"PA is relaxed, no pressure – and is also enjoyable."

Case study 1

Safe play, greater say – Dalmarnock Millennium Play Association

"People were getting excited – pushing people out of the way to get to the board."
Jeanette, young woman

The Dalmarnock Millennium Play Association is a local community-based organisation in Glasgow's East End. It works in partnership to deliver a safe and secure play environment for local children and young people.

The children, young people, parents and grandparents highlighted the original concept of safe play. There was nowhere locally for children and young people to play and they thought the Community Health Project could help them with this. Having practised PA successfully in the past, the project team thought this type of health initiative would be worthy of PA development. It would allow the local community, particularly children and young people, to have a greater say in the planning, development and delivery of their own project.

PA was used to assist the young people to identify their needs, how they could plan and carry forward the process, and how this would result in a tangible outcome beneficial to the whole community.

PA tools and techniques such as spider diagrams, timelines, responsibility matrices and 3-2-1- prioritisation were used to:

- Gather initial thoughts, views, ideas and visions
- Record progress, timescales and deadlines
- Identify who needed to become involved
- Identify what resources the group required
- Prioritise what they saw as the most important issues.

At the end, the whole group felt positive about the experience. One young man said: ***"PA is relaxed, no pressure – and is also enjoyable."***

The young people liked the fact that they could be anonymous: ***"People don't have to put their names to statements."*** said one young woman. They also liked the fact that "everyone has a chance to speak" and "no-one hogs the limelight".

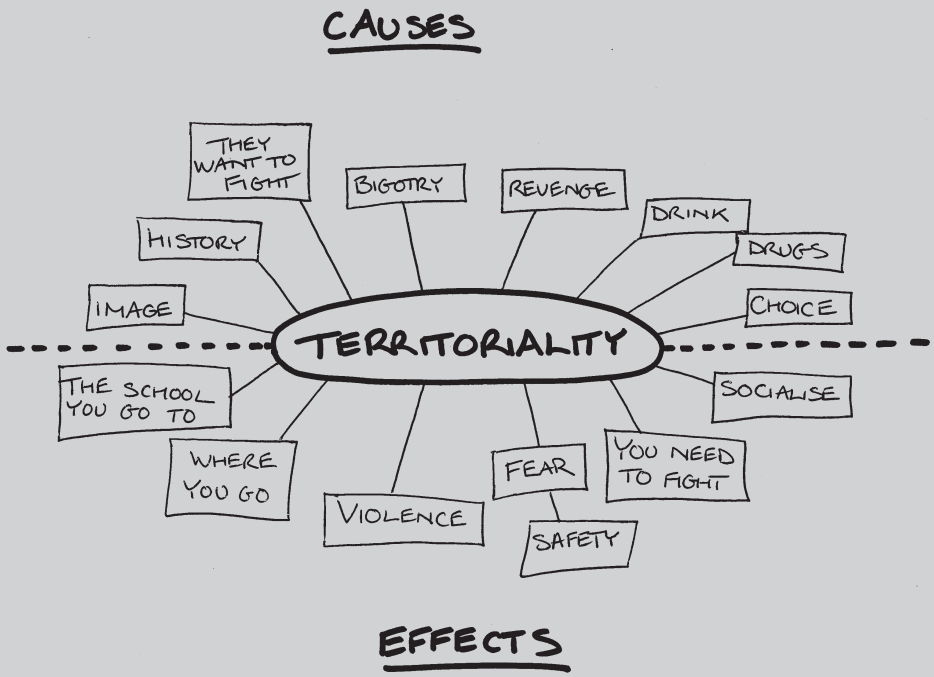
Using PA methods, tools and techniques enabled different age and gender groups to work together to explore differing ideas and opinions and reach a collective agreement on the way forward. ***"The answers came from the group"***, said one young man. ***"If not for PA the plan would have been written by the community health worker of EEHA and the community development worker of social services,"*** said another.

The PA process also allowed for the development of confidence, self-esteem and the enhancement of abilities that are found in every local community.

"It is very clear that PA assists to bring out the very best in people irrespective of age, gender, ability and opinion," said one EEHA worker.

Case study 2

Health and territoriality in the East End



The Health Strategy sub-group of the East End Social Inclusion Partnership asked East End Health Action to facilitate a series of focus groups looking at particular health issues that have a profound effect on the East End and its residents.

The overall purpose of the focus groups was to give local people the opportunity to help influence future health policy development for their area. This case study focused on one of the key health priorities: "reducing the impact of territoriality" (including bullying and violence).

The focus group consisted of young men, young women, workers and parents with teenage children. They all highlighted territoriality as a key health issue in the East End.

They began with a mapping exercise looking at:

- Where people can go in the East End
- How they got to where they were going
- Why they go there
- Different landmarks/services/issues in the area.

The participants were separated into three different groups:

a) Workers and parents of teenage children. The map produced by this group highlighted services that exist all over the area.

b) Young men. They prioritised different areas and used materials to show boundary lines of "gangs". This clearly showed the physical effect of gang territoriality.

c) Young women. The young women concentrated on the whole of the area and showed places that they went to themselves. It did not show the level of boundaries identified by the young men.

Additional PA methods were used for further discussion, namely causal impact, which allowed participants to discuss the relationship between territorial issues that cause the problems and the effects they have on individuals and communities.

The group then carried out a 3-2-1 prioritisation exercise to look at solutions to the causes and in turn prioritised them in order of importance. Some key issues included:

Young men - *bigotry, drink, drugs, history, image, revenge, violence, "the school you go to", fear, "they want to fight/you need to fight"*.

Young women - *bigotry, boredom, gang fighting, religion "in school is different from out of school".*

Parents - *crime, lack of freedom, isolation, limited choices, discrimination because of the area you live in", financial issues, religion, drugs.*

Workers - *lack of amenities, boredom, unemployment, fear, poverty, addiction, rebellion, vandalism, status, limited life chances, peer pressure.*

Solutions and priorities included:

- An increase in the number of youth clubs
- A reduction in the amount of drugs that young people take
- An increase in mixed youth groups from different areas to break down the existing barriers
- Better communication
- Schools taking responsibility to address the issue of territoriality, bullying and violence
- Workers identified several solutions but focussed their priority on resources and targeting policy-makers
- Parents also had several solutions. Their focus was on education for positive parenting practices and tackling unemployment.

Although there were mixed views from the different groups, there was also some consensus that territoriality has an impact on the community as a whole and that solutions have to be developed as part of a wider regeneration strategy for the area.

Case study 3

Talking back – young people's health in Greater Easterhouse

The first experience of PA in Greater Easterhouse was "Talkback on Health". It has been used as a reference in the development of the local Health and Wellbeing Strategy. This positive experience needed to be built upon and in 2001 the Greater Easterhouse Community Health Project identified that there was a very large gap in the provision of health services for young people of Greater Easterhouse. There were some alarming statistics:

- In 1998, almost one in five women became parents before the age of 20. This was an increase on the previous two years.
- The number of terminations was also increasing and the average age for a termination decreasing.
- The number of single parents was steadily increasing, with young women having babies at an increasingly young age.

There are clear links between unplanned pregnancies and social deprivation. Previous PA work had highlighted sexual health as an important issue for the local area. The Health Project worked with the Local Health Care Co-op (LHCC) to compile a funding application to the Scottish Executive's Community Safety Budget for resources to develop a locally based young person's health service.

This bid was successful. A project co-ordinator was appointed and a multi-disciplinary team of LHCC Staff, local youth workers, health project staff and community representatives was established to undertake PA training.

As a result of the training, a vast amount of information emerged on the expressed health needs of the young people of Greater Easterhouse. The young people involved were keen to assist in ensuring the development of a local service which met their needs. They were excited at the prospect of having their own health services, shaped by them and delivering what they felt they needed.

The young people were asked to present the findings of the PA process to the SIP Board. ***"They were very nervous"*** said Gaille McCann, the project manager. ***"But they were fantastic. The SIP Board all still remember the passion with which they spoke. No-one could challenge what they said because it was based on their own experience. It gave them a lot of confidence to be able to do this."***

She continued: ***"I was amazed at the level of information that PA generates. This piece of work proved to me the validity of using PA as a method of recording community views. It has become accepted practice in Easterhouse which is the measure of its success."***

4 What difference does PA make?

The evaluation explored this question with different stakeholders within the process – community members, project workers, SIP members and so on. This was done in interviews and discussion groups with key stakeholders, partners and community members involved in the PA processes in both the East End and Easterhouse SIP areas.

From a community perspective:

It is obvious that the community members found the PA process accessible and easy; what was clearly important was the openness of the process, especially in comparison to other standard survey techniques:

- ***"Visual – can see issues in the community clearly"***
- ***"Questionnaires are limited to answers and you could not talk about anything. With PA someone is talking to you and you can see that people feel the same way about the area and we had the same ideas about what we want"***
- ***"PA can be done in a short space of time"***.

Also of clear importance to people is that PA is more equitable than other processes: ***"the group is equal – no one steals the limelight"*** and ***"everyone has their say in PA".*** And that it is focussed on what to do about a problem, not just identifying problems but also ***"allows identification of solutions."***

SIP Health Strategy group level

Members of the SIP Health Strategy group could clearly see that there are real possibilities for PA to facilitate a different way of influencing policy – ***"asking people and not doing for them".***

They acknowledged that it had value as a process that would enhance the impact of the Health Strategy work – ***"matching decisions to need", "creative process for ideas and lateral thinking".***

SIP Monitoring and People's Panel

The value of PA as a survey technique that complements other more formal, mainstream processes was highlighted by this group:

- ***"Complementary to surveys; in-depth information vs surface questions; variety of methods; quality information vs low return of questionnaires; open to everyone and more participative"***
- ***"Informal process providing formal evidence in the way of reporting and collective views"***
- ***"Gather information from communities about their priorities, challenges and how to tackle them."***

"PA takes you a step further in project planning."

In addition it was seen as having added value, in that ***"PA takes you a step further in project planning"*** and is ***"interesting to all involved".***

SIP managers

There is an interest at this level in the process of participation in achieving the aims of the SIP, and PA meets many of the challenges that building inclusive decision-making faces – ***"PA is an impressive process in terms of engagement with a big number of people and involving young people"*** and ***"the timing for PA was right, as there was a need for a new model".***

Organisational level

At this level, people are really trying to find ways of engaging with communities in a meaningful, practical and realistic way. They have found PA to be a really useful addition to their toolbox of approaches:

- ***"PA tends to move forward in community what is already in process"***
- ***"People open up because of the anonymity of PA – not signing your name"***
- ***"PA as a process is fascinating, people are not threatened by it as it involves more participation – they would equally participate with decision makers."***

On completion of the evaluation, the researcher identified a number of risks and challenges to their "success". These were listed under three main headings: process, tools and participants.

1 The process

- PA could be limited to using participatory tools for rapid appraisal if it doesn't include action or community engagement in decision-making
- If action is not an intrinsic part of PA, community empowerment could be undermined
- The "political" element of PA may pose a threat to policy-makers as well as to those involved in PA
- Key stakeholders may not understand PA principles or be committed to its ultimate goal of social change
- Community expectations may be raised and then not fulfiled
- At a practical level, PA requires time, networking and ongoing support.

2 The tools

- Could be disempowering if the level of confidence and understanding is low
- The innovative and participatory elements of PA pose a challenge to the mindset of the users of conventional methods
- Because the tools are unfamiliar to some they could be seen as more risky than conventional methods
- Sufficient time for reflection is crucial for effective use of PA tools.

3 The participants (individual, community and organisational)

- People's expectations of the process can be set too high, leading to disappointment
- If no action takes place, PA can be disempowering
- It is a problem if key stakeholders don't buy into, or don't follow through, the process. Ultimately, it is decision-makers who decide whether to put ideas into action
- Sometimes there is a climate of mutual suspicion between communities and outside agencies
- The learning process needs to feed into other strategies if it is to be effective.

5 Good practice – if it didn't work, then it wasn't PA[9]

There is no model way of "doing" PA, because the circumstances in which PA is used will determine what constitutes good practice, but the project can be judged a success if the people involved feel they have:

- Been listened to
- Been able to express concerns and ideas
- Can see that they have been involved in an inclusive, transparent and action-oriented process
- Can see positive change.

There are also many examples of bad PA:

1 Extractive

The information raised during the process is taken away by the outsiders/researchers and they decide what should or should not be done as a consequence of the analysis. This doesn't allow the community a real say in what is being decided, and may leave people feeling "tricked". This is what some people call "extractive" – taking the information away.[10]

2 Limited

Only a small sector of the community is involved in the exercise, and so the information raised represents the view points of a limited number. This sector could be defined by age, gender, ethnicity, social class, and employment status etc.

3 Superficial

The process is superficial, finding out problems but not taking analysis forward and exploring solutions.

4 No action

The process is not tied in to decision-making, and so it might be difficult to take the outcomes forward into action. Or else those people who are able to make decisions do not take action as a result of the process.

Principles

PA tools are only as good as the skills and attitudes of those using them. So it is the behaviour and attitude of the PA practitioners that is the most significant factor in ensuring that using PA leads to community empowerment. The underlying principles of PA are very much those of very good community development practice and are:

- **"Handing over the stick"**; this is one of the earliest principles of PA, and refers to a meeting in India where the person who wanted to speak had to hold a stick to show that they had the floor. It is about ensuring that everyone has an opportunity to express themselves and participate, but also about listening to and respecting what they say
- **Who are the experts** and what are they expert in? We all have expertise in something – and community members are experts in their environment and their lives. Professionals come into this with expertise which can be useful, but only when applied to a correctly analysed problem
- **Building trust** and respect between different participants. Transparency plays a very important role in this
- **No one way is right.** There are many different ways of doing things – running meetings, expressing opinions, thinking about problems and solutions. Most conventional consultation techniques revolve around the written word – eg through materials circulated prior to a meeting, or through a questionnaire – and not everyone is comfortable with that. Moving away from this does not mean that you lose rigour – PA processes are systematic and structured and can be far more robust than so-called "scientific" ones
- **Clear agenda.** There needs to be a clear and agreed agenda, with appropriate boundaries around the discussion
- **Appropriate level.** People should be able to engage at the level that suits them. This is really important for most people – both in terms of how they participate and the amount of time that they might be able to commit to the process

"If not for PA the plan would have been written by the community health worker of EEHA and the community development worker of social services"

[9] Statement made by participant of a workshop held to reflect on using PA (Oxfam, April 2001)

[10] In certain circumstances this can be appropriate, but it is important to be explicit that this is what is happening, and not refer to it as PA. This is a similar and less participatory approach; often call Rapid Rural Appraisal (RRA).

An outline of a good PA process

– see also checklist on the inside back cover.

Preparation:

Identify aims and objectives

The overall aims and objectives are often set externally or by change agents. However, the purpose of the process does need to be clear - is it to define community needs and priorities, to design an intervention/project, or to influence local authority policy-making? The aims and objectives need to be clearly communicated and acknowledged by all; in smaller projects they can often be negotiated and sometimes developed and agreed, by everyone taking part.

"PA as a process is fascinating, people are not threatened by it as it involves more participation – they would equally participate with decision makers."

Develop a strategy for achieving those aims

This is a key activity at the beginning of the process and will help increase the chances of a positive outcome at the end.

Answers to questions such as:

- Who are the community? Who has influence within the community? Who does not?
- What are the issues to be addressed?
- What is the context within which this is all happening?
- What are the decisions that are to be informed/influenced by this process?
- Who are the key players? - in the community, outside, decision-makers, etc.
- How and when should you bring them on board?
- What capacity building opportunities exist for staff and local citizens through PA Training?
- What are the human and financial resource requirements?

A strategy on how to deal with key areas needs to be developed, implemented and revisited as the process unfolds. PA is a dynamic process that includes both action and reflection. It is important to keep examining the level of stakeholders' involvement at the various stages of the PA process.

Involve people

Map out who the key players are within the community. Who are the groups that you want to draw in? How can you access them? How can you work through existing groups? Are there power issues within the community that you should be aware of? Which key stakeholder aren't part of these existing groups? How could you bring decision-makers into the process early on? If they understand the process better they are more likely to respect the outcome.

Communicate about the process

Awareness needs to be raised of the process. This needs to be targeted – if you think using PA is going to be a culture shock for some people, think about how you can introduce it to them. Often just doing the exercises, giving it no special status, is the easiest way. One way with decision-makers is to facilitate a meeting using some of the tools.

As the PA unfolds:

Keep records

Archive the "visuals" and jot down consistent notes – agree beforehand what you will record as a standard minimum. Also, the visual can help recall the discussion and the particular emotions around it – also useful in interpretation. Make sure you note who the participants are – women or men: their age, ethnicity, etc.

Find time for reflection, analysis - and flexibility

As discussions proceed and the process unfolds, flexibility is key. Regularly asking the questions, have we missed anyone? Have we explored an argument deeply enough? Whose voices are being heard and whose aren't? Plan this time into the process.

Reaching the parts…

Some people are hard to reach – for example, there are the obvious problems of childcare and transport. Others may have language support needs. Lack of confidence and trust in participating are much more difficult to tackle. Explore what the barriers might be including enough time

in the process, and work them through – you need to prove that there is a point in participating. You need to check throughout the process-are you meeting your target groups? Are the participants truly representative of these target groups? Have participants been able to voice their concerns? Are both men and women participating and voicing their concerns?

Deal with tension and conflict

Unfortunately, when this type of work uncovers conflict, this often means that the process is abandoned – however, the conflict or the problem won't go away on its own. Experience has shown that careful use of PA has been effective in helping to facilitate conflict resolution.

Focus on action

Ensure that the process is not just about gathering problems and issues. Develop tools that are analytical and dig a little deeper into issues and you can start to develop solutions and actions.

Don't dump issues

If you are a health project and an issue raised is about housing, don't just put it aside, saying "not something we can deal with". Make a plan with people to take the issue forward to the housing department. People's problems don't fall neatly into sectors the way government has ordered its services.

Build in verification

In a really good PA process, the report, or action plan, at the end is a product of a rigorous process of discussion with different members of the community. This needs to be tailored to fit the needs of the community. It might mean that a meeting, or a community day might work better. Verification does not have to be a one-off occurrence; it can be built into the process as you go along as part of the reflection cycle.

Maintain momentum

It is only natural to feel "stuck" at a certain point when using PA tools. Additional training input is useful for project staff, and networking with other practitioners can widen the scope of skills and expertise.

The report

The hallmark of a bad PA process is the production of a report that is viewed as the outcome. However, a report of the process, capturing the main decisions, can be an important part of the strategy to achieve the desired change. Different reports may be needed for different audiences.

However, the outcome of a PA should not be a report – it should be decisions made that lead to positive change in a community. It is important to guard against report preparation high-jacking energy and resources just at a time when it is key for those to be directed at decision-makers. This is also why investment in the decision-making processes throughout PA is so important, as success is not so dependent on the report itself.

6 Ways forward

There are a number of issues that the evaluation and the PA work in Easterhouse and the East End have raised. These need to be thought through and addressed in the future, if those using PA wish to maximise its impact. Some have been addressed in the section on good practice, but there are also some issues that need to be tackled in a wider arena.

"PA builds up confidence as individuals and as a group."

- **Defining processes and their potential:** there are many participative processes being used and undertaken in community development and social inclusion work. It is important that all these techniques and approaches are clearly defined and their potential understood by all stakeholders. PA is being used to describe a range of processes from Rapid Rural Appraisal, to Participatory Learning and Action. It is important that there is a common understanding of what these processes all are, how they differ and where their use is appropriate or not.

- **Sharing learning:** one way to achieve better practice - and also to address the above – is to ensure that there are dynamic exchanges of experience between practitioners – new tools, new ways of using old tools, how to achieve greater inclusion, etc.

- **Reflection:** PA is a very reflective process - it encourages review and promotes learning, both of community development issues and also of its own process. It has developed internationally through a wide and open discourse about what works, what doesn't, etc. At present this is limited in the UK; partly due to the plethora of "participation techniques" on offer, many of which are provided only by consultants, and partly by the pressure to meet deadlines. This prevents active reflection and sharing of learning. As some of the techniques are "owned" by certain stakeholders, there is no room for failure and so no room for evaluation, and there is just not the time or space in work schedules. How to develop this, using information technology as well as other more conventional methods, is a key issue. In some areas, this has been achieved through local networks of PA practitioners.

- **Raising awareness:** one of the barriers to PA achieving its full potential is that decision-makers and community members do not understand the process. If they are suspicious, then this will undermine the process completely. Changing the way discussion happens is a challenge for many people, and so they need to learn to trust the process before they engage in it. Raising awareness of PA – how it can be extremely rigorous, how it can facilitate a more open and forward-looking discussion – is key to enhancing its impact.

- **Training:** this is a key issue. Both projects received tailor-made training from consultant trainers. Both felt that the way that they received training was absolutely key to their ability to use PA – the training focussed on a project, there was a great deal of mentoring and support throughout the process, and this led to sound capacity within each project. Many of the staff have now moved on and taken those skills into other programmes. At one level this approach would appear to be expensive, but other projects have found that sending staff on prearranged courses has not led to any significant change in the way they carry out their work – people have found it difficult to put into practice what they learned on the course, and so in the end this has been a wasted investment. Local training, possibly within the voluntary or statutory sector, with access to mentoring support afterwards, would be ideal and there are a few models of this around the country (see for example Walsall PA network in section 7).
- **Costs:** For a tailor made process – ie with a consultant – the costs can be between £5-10,000 (depending on the number of days, consultant fees, etc). Off the peg can be £300 to £500 per person for a 4/5 day course (excluding accommodation, etc).

And the story continues....

We hope that you will have found this report useful. There follows an extensive list of people and organisations to contact to implement your own PA process. We continue to learn and to use PA ourselves in a variety of ways - once started, PA doesn't just end, because the outcome of a good PA process is more of the same - using the PA approach to continue dialogue, to review and monitor change and to tackle the next priority issue.

One final practical example of the ways that PA has changed those involved. When the play area was being built in Dalmarnock (see Case Study 1), there was a stage when the workers didn't seem to be doing anything. The young people who had been involved in the PA process had the confidence (that they would not have had before) to knock on the workers' van to ask them why they weren't doing their work. ***"We've done our part,"*** they said, ***"where's yours?"*** The young people then asked East End Health Action to address the issue in the next committee meeting. The process led the Millennium Play Association to come up with specific action points to take forward as a steering group. The young people recognised that they had changed as a result of the PA process, but also felt that they were being listened to and their ideas acted upon. As one put it: ***"PA builds up confidence as individuals and as a group."***

"Now everyone wants to be PA'd" said Christine from East End Health Action, ***"Even if they don't know what it is!"***

7 Useful contacts

From the report:

East End Health Action (EEHA),
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Others

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Relevant publications:

Fifty voices are better than one; Combating social exclusion and gender stereotyping in Gellideg, in the South Wales Valleys, Gellideg Foundation Group and Oxfam GB, March 2003. Available from Oxfam UKPP (address given above) or can be downloaded from the following website: www.oxfamgb.org/ukpp/resources/index.htm

Participatory Learning and Action: A Trainer's Guide (1995), Jules Pretty, Irene Guijt, John Thompson and Ian Scoones. IIED. ISBN: 1 899 825 00 2.

PLA Notes, in particular Issue 38 'Participation in the North' (June 2000). IIED. ISBN: 1357-938X.

Reaching the parts; Community mapping: working together to tackle social exclusion and food poverty (2000), SUSTAIN. ISBN: 1 903060 125.

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