Participatory research in health: Setting the context

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1 Participatory research in health: setting the context[1]

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Many contributors to this book assume some familiarity with concepts which may not be familiar to all health professionals. Our aim in this introduction is to set into context those issues and theoretical concepts which are frequently referred to in the text. These include educational processes based on Freire's critical pedagogy (Freire 1972), issues around difference, for example in gender, and contemporary notions of knowledge production.

Why use the PR approach in health?

Participatory research (PR) and associated methodologies such as participatory rural appraisal (PRA), and the more extractive approaches such as rapid rural appraisal (RRA) and rapid assessment procedures (RAP), are considered increasingly important in the field of health. There are different reasons for the growing popularity of these methodologies. First there is an increasing recognition of the gap between the concepts and models professionals use to understand and interpret reality and the concepts and perspectives of different groups in the community (Grandstaff et al. 1987; WHO 1973). The biomedical interpretation and understanding of diseases, supported by studies carried out in laboratories, is in many cases different from the understanding embedded in a local culture and history. For example, a study in Tunisia shows that causes of diarrhoea similar to a biomedical explanation of diarrhoea are seen as only one possible cause among many others by the people involved in the study (Aubel & Mansour 1989). The implication is that communication about diarrhoea is much less straightforward than many health workers thought. Second, many factors, cultural, historical, socio-economic and political, which are difficult to measure have a crucial influence on the outcomes of interventions and efforts to improve the health of people: '[Development work] cannot ignore these factors and pretend that the world outside the laboratory is the same as inside' (Lammerink & Wolffers 1994:7).

Small-scale qualitative and rapid appraisal procedures aim to generate knowledge and information which represent the perceptions, concepts and practices of different groups and communities in a relatively short time. The emphasis is on generating knowledge from the perspective not only of the researchers but also of the researched. Qualitative research and rapid appraisals help to identify local needs and priorities, place issues in the context of people's lives and give direction to programme development and service provision. These methods are used increasingly in the development of specific disease control (Vlassoff & Tanner 1992),

in health education interventions, such as diarrhoea (Bentley et al. 1988), nutrition (Scrimshaw & Hurtado 1987; Varkevisser et al. 1993) and more generally (Aubel 1990–91; Ramakrishna & Brieger 1987), and in assessing community health needs (Annett & Rifkin 1988).

The development of *participatory* rural appraisal, which evolved in reaction to the more extractive approach that characterizes *rapid* rural appraisal (Chambers 1990), is of importance. Within PRA there is a clear emphasis on learning with and from groups in the community in a relaxed and flexible way. PRA methods work through a powerful visualization of situations and knowledge generated in dialogue with local people, and have expanded the ability of many grassroots organizations to trigger discussion and to document and acknowledge local knowledge. Alice Welbourn (1992) shows how the applications of these methods in the field of health help to document differences between groups and their potential for initiating dialogue on health needs and priorities. Marindo-Ranganai (chapter 16), Oranga and Nordberg (chapter 17) and the SEWA team (chapter 12) describe, in this volume, how PRA methods were useful for involving community groups in documenting health information and demographic data.

Many workers in the field of health have been exposed mainly to quantitative research methods and, frequently, one of the first questions asked is: how valid and reliable are the PR methods?

The validity and reliability of qualitative data collected by PR methods

The debate about validity and reliability of qualitative data and participatory appraisal has developed substantially over the last decades. Few people who are in touch with the debate will question the possibility of obtaining valid and reliable data through qualitative and participatory methodologies. Maxwell draws our attention to the fact that validity always relates to data or interpretation of data. Methods are appropriately or inappropriately used to obtain data. An inappropriate choice of methods or the misuse of methods can be a threat to obtaining valid data (Maxwell 1992). In the literature about validity and reliability in qualitative research a variety of terms is used. While some authors refer to validity and reliability, others, such as Patton (1990) and Pretty (1993), use words like 'trustworthiness' and 'credibility' to address the concept of validity in qualitative research. They argue that the threats to validity and the ways we try to ensure validity are different when using qualitative from when using quantitative methods. To avoid confusion they suggest the use of a different terminology. The validity of research findings can be assessed in various ways. This may be done for example, by those responsible for data collection checking with participants in the research

that the information collected from them accurately reflects the meanings respondents have sought to convey. In the course of data collection interpretation of data and conclusions drawn by researchers can be confirmed or disputed by the respondents. If the findings are confirmed as accurate then the credibility of the findings is increased greatly. Another way of enhancing credibility would be to hold occasional meetings with peer groups from the same community but otherwise not involved in the study. This helps researchers become aware of possible gaps, bias or error that they might otherwise have not been aware of without careful searching and probing for accuracy in meanings. PR, like qualitative research, seeks to examine and reflect the full context as far as possible by providing detailed information about the research community and offering precise quotations that validate statements on which findings are based (Pretty 1993). Tolley and Bentley, in chapter 5 in this volume, emphasize the need to offer trainees in PR the possibility of learning to cross-check information by using a mix of methods and of discussing an issue with different groups in the community.

Different interpretations of PR

Different interpretations are given to PR. These range from the researcher and research community designing the research together, researchers designing the study and then collecting data with the help of the community, to the community working closely with the assistance of a non-governmental organization (NGO). For some, PR means involving field-level health workers in the research in order to sensitize them to the needs of the community; for others it means research which is an integrated part of a process towards empowerment and emancipation. We think it is important to avoid adopting a purist attitude towards participatory research. At the same time it should be recognized that participation should genuinely be empowering and not just a situation where local people work with a researcher for the latter's convenience.

The quality of participation in PR can be evaluated by addressing a series of questions to the research process. For example, does community participation occur at all stages of the research (initiation, design, data collection and analysis, interpretation of data, discussion, presentation and dissemination of findings) and, just as important, which groups in the community are represented in which of these processes? There may be several reasons why representative participation of the research community has not occurred at all these stages. The research may not have focused sufficiently on local needs, or particular technical skills may be required which at the time the research community members may not possess, or the research community may have more pressing priorities, such as care of dependants, or ensuring a daily income to the household (Pratt &

Loizos 1992). On the other hand, lack of participation may occur because the researchers want to maintain their control over the research process. Some of these issues can be usefully addressed to the PR process in order to evaluate the quality or lack of quality of participation and to identify reasons for this. One of the unique qualities of PR is that of serving the shared interests of both researchers and researched. This may come about through a complex and often long-term process of negotiation. In her contribution to this volume, Marion Martin in chapter 8 examines aspects of this complex process of negotiation, with a particular focus on the movement of power between researcher and researched community. She does so in the light of her experiences working with a well-woman group in the United Kingdom.

Participatory research goes beyond documenting local people's needs and perspectives. PR emphasizes the *process* of knowledge production. First, it helps especially marginalized and deprived people to gain self-confidence and pride in being able to provide a useful contribution to community life. Second, it builds respect and empathy in professional groups for the insights and knowledge people have and the problems they face. Third, listening to local people helps to avoid mistakes and to develop programmes that take into account the specific situation and conditions which will influence the outcome of programmes (Chambers 1983). It helps to explain why interventions are not or are only partly successful. For example, visualization methods such as body mapping combined with individual and group interviews have emerged as useful in documenting and understanding local people's concepts of their body, providing a starting-point for improved communication about sexual practices between health professionals and the women in the communities involved in the research (MacCormack 1985).

Whilst the use of qualitative research in health and the concept of community participation have been discussed at length in a variety of professional journals, practices in, and concepts of, PR are much less shared and discussed. The aim of this volume is to present an overview of the historical and more recent development of PR and to share experiences and reflections on practice in a variety of settings in the field of health.

History of participatory research

The initial development of PR or participatory action research (PAR), as it is also called, originated in countries in Latin America, Africa and Asia. The common ground in the push towards this practice was the concern with persistent inequalities in the distribution of power and resources, and the processes which help to keep in place dependency and domination in the relationships between privileged dominant and marginalized groups of people. There was a growing awareness that to fight oppression

and alleviate poverty one needed to address the feeling of helplessness that is associated with it. Pioneers in PR such as Fernandes and Tandon, Fals-Borda and Rahman, and Hall emphasize the need to link research with empowering education and action (Fals-Borda & Rahman 1991; Fernandes & Tandon 1981; Hall 1981). Budd Hall was one of the first writers also to emphasize PR's importance in the development of health programmes (Hall 1981). The emphasis in primary health care (PHC) on community participation has encouraged health professionals to look at the implications and relationships between that and research. Many of the initial applications centred around involvement of communities and health professionals at field level in needs assessment, planning and evaluation of programmes (Feuerstein 1988, MacDonald 1986, Nichter 1984). Since then other influences have contributed to further development of participatory research. In the last twenty years it has become more familiar in a diversity of disciplines and settings such as rural development and agriculture, community development, health and education.[2]

A more in-depth discussion of historical and contemporary influences on PR is presented by Rajesh Tandon in Chapter 2.

Educational processes and PR

Education has played an important role in the development of the concept of PR. The educational aspects involved in a participatory research process were a central element in the practice of adult educators in the South. They were the first to articulate the phrase 'participatory research' and promoted PR through the International Council for Adult Education. Adult educators in their education practice genuinely believed in education that helped the learners to establish control over their own learning process. Based on this experience and the realization that their research practice contradicted their education practice they started to reformulate their approach to research (Tandon 1988). Many contributors to this volume restate the emancipatory, transformative character of PR. Maguire, for example, states that:

> PR can be utilized to create knowledge and take collective action, short and long term, for potentially emancipatory, transformative structural and personal change.

Action for social change requires an educational process in which researcher and participants develop a critical awareness of circumstances influencing their lives, reflect on what this means in their individual and communal situation and decide what action would be most important and feasible to take.

Linking the process of knowing to learning and action

Paulo Freire had an important input in linking the process of knowing

and learning. Linking knowing and learning through an ongoing cycle of action and reflection, leads to the development of a critical awareness about the world participants live in (Freire 1972). Freire's critical pedagogy has had a significant influence on the work of adult educators and others involved in education for liberation. An example of an application of his work in the field of health is found in the three volumes of *Training for Transformation* (Hope & Timmel 1984). These are based on projects implemented in Kenya and Zimbabwe.

It is not possible within the limited space available to discuss Freire's work comprehensively. His widespread influence on the development of participatory research, however, also shown by the range of contributors to this book who refer to his pedagogy, warrants a more in-depth discussion of some aspects. Facets which have a direct bearing on the PR process include his ideas about the different aims educational processes can pursue and the reasons for linking knowing, learning and action. Freire critiques general practices in education and asserts that most educational activities do not challenge inequalities in the learners' lives but keep them passive and uncritical. This 'domesticating' approach to education fails to help people break through apathy and question the situation they are forced to live in. People who have lived their lives in marginalized and deprived positions need to develop a critical insight into the structures, ideas and practices in society and themselves that place and maintain them in positions of inequality. They can then develop initiatives to change this situation. An example of this in the field of health would be teaching people in a didactic fashion about matters of hygiene and nutritious foods. Such an approach fails to enable them critically to question and come to recognize the reasons why, for example, water supplies are inadequate and food is short, and look at ways in which political, social and personal action can change this situation.

Freire's alternative 'education for liberation' has as its main goal the dynamic development towards a 'critical consciousness'. The advancement towards a critical consciousness evolves through a dynamic process which is informed by critical thought and action. The dynamic nature of this process is captured in the term 'critical transitivity of the group' and a 'critical transitive' individual: 'A critical transitive thinker feels empowered to think and to act on the conditions around her or him, and relates those conditions to the larger contexts of power in society' (Shor 1993:32). Research practices which take away information and knowledge, no matter how valuable in other respects, miss the opportunity to contribute to a process of thinking, reflecting and acting, and deny groups in the community the chance to fight inequalities.

The implication for research that wants to address inequalities is that it must become a continuing process of learning which integrates

research, reflection and action. The consequences, opportunities and difficulties encountered in implementing such an ongoing learning process for research in health and especially health promotion are illustrated by some case studies which are expanded in this volume.

Annie George in chapter 11 draws our attention to the problems encountered when research is carried out by academics whose institutions and funding agencies have expectations, which make an ongoing process problematic. She illustrates the need for an ongoing process after the academics have completed their research. While exploring the meaning of sexuality during focus group discussions, poor women in Bombay shared painful experiences in their lives, established a bond with the other women in the group and discussed the opportunity for collective actions for change. The effects of participating in the research for the women involved differed, depending on the possibilities women had to integrate this experience into continuing action. In groups which were called together by NGOs, whose service did not provide the opportunity to absorb the experiences of women into their ongoing work, the research process reinforced a woman's lack of choices to make immediate changes in her life situation. This experience is contrasted with the experience of working with an existing group of women. As George says: 'For this group of women, the focus-group meetings were a means in their ongoing process of analysing the various forces which were bottlenecks in their search for greater autonomy'.

The implications of the above case study are not necessarily that research should not be carried out by professional researchers. The study merely reinforces the point that researchers need: to seek alliances with groups already in existence; to evaluate carefully the opportunity for groups initiated by the research to continue; to examine how the outcomes of the study can be integrated into existing services; and to look at how community action and lobbying for change can be supported. Furthermore, although there is a need to develop clarity in what it is we aim for in participatory research, there is also a danger in promoting a purist form of PR. A significant value of the contributions and case studies presented in this volume lies in their reflection on the experiences they relate and the descriptions of problems and constraints. Entry points can be identified. As Maguire presents it in chapter 3, we need to: 'look for ways to move deliberately along the participatory continuum'.

To ensure that research can be integrated into further action, different options are suggested. One is the involvement of NGOs, and possibly government agencies, and participants in the early stages of the research. A participatory planning framework used in a training with health professionals working in the NHS in Britain is presented by Grindl Dockery (chapter 15). Mavalankar et al. (chapter 19) and Dockery

highlight the difficulties encountered when introducing such an initiative in government and in strongly service-oriented organizations.

Bloem et al. (chapter 13) and Okurut et al. (chapter 7) illustrate the opportunity for an ongoing process into which research is integrated. They present case studies of implementing research, education and development initiatives in projects in Bangladesh and Uganda which have a strong community involvement. Renu Khanna (chapter 6) shows in her case study of a women's health programme how initiatives to improve health from a biomedical perspective can be integrated into the overall aim of women's empowerment. The programme started with the training of traditional birth attendants which emphasized a learning process aimed at women's empowerment as well as teaching how to perform an aseptic delivery. This project illustrates how ongoing work with women went through a long process of shared learning which led to changes in ideas, insights and knowledge, increased self-confidence, and changes in the perceptions of the women both of themselves and of their bodies. This influenced and changed relationships with others such as husbands and health workers and culminated at community level in women organizing themselves for collective action around their own issues. Khanna presents a model for the development from intra- and interpersonal development to group- and community-level action and changes. This model can be seen as a cyclical spiralling movement where group and community action lead to further intra- and interpersonal development and vice versa.

Personal, interpersonal and collective development and action

Viewing intra- and interpersonal change and community action as interwoven aspects of development towards a critical consciousness is a powerful aspect in Freire's pedagogy and in feminist theory and practice (Freire 1972; Weiler 1991). Ira Shor indicates that critical consciousness can be described as having four qualities: power awareness, critical literacy, desocialization, and self-organization/self-education. Critical literacy means: analytical habits of thinking which go beneath surface impressions, mere opinions and clichés; understanding of social contexts; and discovering the deeper meaning of any subject matter, text, process and situation. Desocialization means recognizing and challenging the myths, values and language learned, and critically examining values operating in society (Shor 1993:32). Internalized images are an important and often insufficiently recognized concept in health education and link up with the potential of badly thought-out educational activities which blame the victim. To give messages to people without investigating what people already know and what are the reasons for health problems is potentially harmful. Freire has pointed out how formal education and a lifelong experience of being named and described by others leads to the

internalization of images of oneself based on the perceptions of others. In keeping with his theory, educational activities can have the effect of strengthening negative images people have of themselves. For example:

> A play is shown to a group of mothers during a mother and child health (MCH) clinic which aims to show the value of good nutrition. In the play there are two mothers. One feeds her child three times a day and has a happy healthy child. The other feeds her child only maize twice a day and has a malnourished child. The health worker then explains to the mothers how they should feed the child using locally available foods. The mother who watches the play and feeds her child only maize twice a day might be made to feel a failure, who does not look after her child well. She might already feel 'good for nothing' because no matter what she tries it will not help. The landlord has just told her not to come back so she will not be able to take the left-over cobs; her husband has not sent money for a while now and the goat from the neighbour has just eaten the young vegetables she planted in her kitchen garden. She might think: 'The play is right, I am good for nothing'. (de Koning 1995)

Freire's theory has implications for the strong focus on individual behaviour change in most health education practice and raises questions around the concept of 'informed choice'. How much choice has the mother in the above example to put the knowledge about nutritious foods into practice? Henriette Moore draws our attention to the debate about the suitability of the terms 'choice' and 'resistance' for analysing processes that are not always conscious or strategic:

> Oppressed groups frequently develop their own discourses that work in contra-distinction to dominant ones, but the questions are, can people actively recognize and choose the subject positions they take up, and to what degree are they able to resist the terms of the dominant discourses? (Moore 1994:4)

Moore debates this issue in relation to the discussions of gender identity and gendered subjectivity, and the relationship of the individual to the social and vice versa. Theories about subject positions and individual and collective identities are not only relevant to issues related to gender, class and race but have implications also for theory and practice in health education.

One implication is that we need to question how the description of the ways in which behaviour affects the occurrence of disease is helpful in influencing and enabling individual and social change. One question that can be asked is related to the generalized description of at-risk groups, at-risk behaviour and identification as being-at-risk, when subsequent interventions do not enable individuals and groups in giving meaning to

and reflecting on the implications of these descriptions.[3] For example, how helpful is it for a young woman to be informed that having sex can put her at risk of HIV/AIDS without giving her the space to reflect and analyse what the decision to have or not have sex entails. She needs to become conscious, in as far as this is possible, of the factors which influence her decision before we can start calling it a decision. How far does she desire to have sex, what are her fantasies about the type of girl she would like to be or she thinks others would like her to be? Where do these fantasies come from? What is the meaning to her of conflicting ideas about what is acceptable behaviour held, for example, by parents on the one hand and important peers on the other, and what are the consequences of taking up a certain position? PR that aims for empowerment and self-determination needs seriously to provide the space for analysis, and reflection on what are the series of congruent and conflicting ideas, self-images, self-representations, fantasies and desires which underlie and make up, for example, an adolescent girl's or boy's position in relation to compliance with, or resistance to, discourses on sexual practices.

Issues around the relationship of the individual to the social also have implications for the way we look at unreflected experience. There is a danger in looking at experience and at information and knowledge as a static given. PRA methods with their emphasis on visualizations, working with groups and the use of drama offer valuable entry points for setting a process of reflection into motion. The requirement is that the methods are used as a trigger for discussion and reflection in addition to documenting the position, ideas and practices which formed the starting-point.

Implications for the role of the facilitator

A process of critical reflection and action is developed to enable us to become aware of where the images, ideas, positions and opinions we have of ourselves and others come from, and to gain the possibility of giving a different meaning to who we are and a different direction to our lives. The use of 'us' and 'we' is important in this context. It is not only the poor, illiterate, and other categories of people classified as marginalized and deprived who need to think about how, in what ways and why they experience themselves and the world as they do. It is equally important for more privileged groups such as health professionals, researchers and activists to do the same. Meulenberg-Buskens in chapter 4, among others, stresses the importance of congruence, which means acting in accordance with the principles in PR when facilitating a training, conducting research and living our lives. In reflection on what was learned in relation to the role of facilitators, planners and researchers, Khanna states in chapter 6 that:

> PAR requires an attitude of mutuality, an openness and a commitment to learning on the part of all those involved. These words have acquired a different meaning for us, as programme planners: we have really learnt how difficult it is to open ourselves as recipients of traditional knowledge. And how difficult it is to leave the position of those who have all the answers.

Desocialization relates to 'recognizing and challenging the myths, values, behaviours and language learned in mass culture; critically examining the regressive values operating in society, which are internalized into consciousness' (Shor 1993:32). To facilitate a PR process which enables people to become conscious of their internalized images, and norm and value systems which are taken for granted, requires a long-term process and workers who have the insight and skills to facilitate such a process. One of the problems in implementing PR in health is the emphasis in health worker training on a biomedical model of health as the only valid framework to explain disease, while communication skills are limited frequently to didactic teaching of groups and giving advice to individuals. Health systems often maintain a strict working hierarchy, leaving field-workers with a similar feeling of helplessness and dependency in their work situation as disempowered groups in the community feel in theirs. Given, however, that it is the health workers at health centre, sub-health centre and aid-post level who need to sustain a long-term communication with communities, it is as important to look at the empowerment and training of health workers in PR as it is for groups in the community.

Verbal and non-verbal communication

Critical reflection and co-learning, verbal and written communication are not the only, nor perhaps the most powerful, forms of communication. The use of visualization methods, such as drawings, charts, maps and drama, can be a powerful strategy to come to a shared analysis of, and critical reflection on a situation. Andrea Cornwall (Chapter 9) draws our attention to the many things that cannot be shared verbally. Sensitive or emotional issues, styles of interaction involved in persuasion, material and body expressions of domination, resistance and bargaining cannot easily be described. She provides an overview of the benefits of visualizations, including the use of drama. One of the editor's own experiences in conducting drama workshops with students from different countries in the UK, and groups of adolescents in Papua New Guinea, shows the potential of drama for acting out and searching for different ways of behaving, triggering a discussion on reasons for individual behaviour and relating these to a wider social and cultural context. The production of a play offers the space to share insights, knowledge and experiences. The observation and analysis of symbolic meaning expressed in body language and the use of space help to describe, reflect on and place in context emotions and attitudes. In the development of

'Theatre of the Oppressed' Boal goes beyond the use of drama which separates actors and spectators. Theatre is based on the observation of how people act in their daily lives and therefore everybody can be an actor. In what he calls forum theatre, discussion and dialogue are replaced by drawing the spectators onto the stage to act and through their acting to give a new direction to what happens in the play (Boal 1992).

The use of drama in the field of health is illustrated in this volume by the contributions of Preston-Whyte and Dalrymple (Chapter 10), and Howard-Grabman (Chapter 14). Preston-Whyte and Dalrymple found that workshops which followed the style of a formal talk did not elicit much response on issues around HIV/AIDS and sexuality. They then developed a drama workshop for teachers, who were encouraged to use this method with their pupils. The development of the plays in which school children, for example, 'graphically portray the scene in bars in which older men persuade young girls to have sex with them' shows the potential of drama to trigger an in-depth discussion about the reasons for girls consenting to sex, and an acting-out of different interactions. Although the plays at the moment are very much aimed at disseminating messages without discussion or critical reflection, the potential for addressing issues around gender roles, sexuality, reasons for resistance and consent are recognized, and ways to introduce this are sought. Howard-Grabman describes the use of drama for eliciting women's views on issues and problems related to maternal health.

The issue of difference in PR: gender and other factors

An important influence on the debate and development of PR is the feminist movement. Feminist researchers and action groups in different countries have emphasized the differing experience of women and men and the need to enable groups of women to pose problems, and to subvert private and public decision-making processes and relationships. PR aims to work with the poor to enable them to take more control over their lives. But who are these poor people? There is a danger in the use of categories such as 'the poor' which implies that communities of poor people are homogeneous entities. Feminist theory and practice have highlighted the need to look at the differing experiences of women and men to question all seemingly homogeneous categories. Several aspects play a role in the study of difference. One of the issues is who is actually given a voice by being included as participants, and whose ideas are informing the results. Maguire has documented how the specific context of PR, as it emerged in the 1970s, centred around male power, perceptions, problems and experiences. This male-centred view failed to recognize women's differing experience, and gender issues were not on the agenda. The feminist movement has started to re-address the male bias of

many research projects other than all-women PR projects, where knowledge is both provided and produced by men, and women are largely excluded and invisible (Maguire 1987).

The use of abstract categories such as 'the oppressed' or 'the poor' raises further questions about difference, both in terms of the development of theory and in practice. Paulo Freire, like many other men writing about human experience in the sixties, failed to address differences between and among groups of oppressed people. By treating the poor as a single category, Freire suggested that the meaning of oppression and paths of action towards liberation were the same for all oppressed people. His examples include bosses oppressing workers, and men oppressing other men (Freire 1972), but he failed to look at situations where, for example, men who are oppressed in the workplace return home to become oppressors of their wives or daughters and sons (Weiler 1991).[4]

The use of 'women' as a unified category has been challenged by feminists in developing countries. They show us that the meaning of being a woman differs, depending on the specific place, situation and time. Many feminist and all-women PR projects have started to address the issue of difference. Alice Welbourn shows how the use of different PRA methods enabled her and the participants to document and raise awareness about the different experiences, insights and ideas of individual women and groups of women (Welbourn 1992).

It is one thing to identify differences but another to deal with the conflicting interests that emerge. Reports on the use of PRA/RAP and other qualitative research methods have emphasized the following: insights provided by these methods into what different groups of people know, think and feel; the enhanced confidence of participants in their capability to produce valuable knowledge and insights; and the effect that sharing experiences and knowledge has on the ability of communities to recognize different and in-common perspectives. Generally very little insight is given into the negotiating of different interests within the larger community. Obviously it is much more difficult for less influential groups to have their interests taken on board if these are in conflict with the interests of others. Worse, action taken by a group which has not thought through the potential backlash (and if and how it can cope with that) can be a disempowering experience. This can lead to lack of hope and confidence in the possibility of change. Strategic planning of action should include, therefore, the anticipation of possible reactions and how they will influence the development of a particular group. It is an essential part of enabling less powerful groups to act in their own interest.[5]

The question of how to negotiate the needs and priorities of different interest groups has direct implications for policy makers and planners in

health and development. One possible practice is advocacy and lobbying to get interests taken on board by special interest groups. There is a need to look at the role of governments, donor agencies and their workers in providing a space for the least powerful groups to have a voice and to give them the possibility to influence decision-making.

Influences on ways knowledge production is perceived

Tandon highlights the influence of critical social theory and phenomenology (a philosophy which recognizes bodily experience as an important source of knowledge) on what are seen as legitimate ways of knowing. Insights derived from these perspectives emphasize that knowledge is conditioned by the historical context in which it develops, and that lived experience is implicated, albeit in a problematic way, in the creation of knowledge. Tandon and Maguire draw our attention to the implications of the notion that knowledge is historically produced, mediated and legitimized from the perspectives of the dominant classes. PR, as an alternative to research determined by the dominant groups, aims to produce knowledge from the perspectives of marginalized, deprived and oppressed groups of people and classes, and in so doing so aims to transform social realities.

Foucault's theory of how knowledge is produced and how power operates provides a useful framework for looking at the process of changing social realities. Arguably his greatest contribution to PR is his position on power relations. In Foucault's opinion, knowledge production is not the result of simple bipolar relations of power and powerlessness. Relations of power take specific forms in particular societies, and are organized through, for example, relations of class, race, gender, religion, sexual preference and age. In Foucauldian theory there is a direct relationship between the production of knowledge, social practices, and ways of being. Dominant knowledge systems can be resisted, consciously or subconsciously, by alternative perceptions and forms of knowledge. Alternative forms of knowledge exist and/or are produced at individual and group levels and their social power is increased through sharing and a winning over of others to accept these forms of knowledge (Weedon 1987).

Andrea Cornwall shows in her work with local women and health workers how the conceptual framework, introduced by health workers, of what contraceptives do to women's bodies did not fit the knowledge local women had about their bodies. Because of this, both health workers and women were left with a feeling of being inadequate. Cornwall then describes how individual drawings of the body and its functions, by local women and researchers, helped both groups to visualize, discuss and understand the different frameworks. Subsequent drawings in small groups and discussions about what was an acceptable framework to

explain women's bodies and the working of the Pill produced a new commonly accepted framework. As Cornwall (1994) puts it:

> The idea of giving people information implies that knowledge is a thing that can be acquired or lost, rather than a process which is always in the making. We know our bodies in many different ways; our knowledge is dynamic, changing with new experiences; they too are in flux.

Different interpretations of what constitutes reality potentially have the power to influence services provided and action taken. The model emphasized depends on the power relationships between the different agents involved. Susan Rifkin makes clear how in the field of health, the bio-medical model and medical practitioners have a powerful influence on what is seen as health, and on what services should be provided and what policies developed (Rifkin 1994). The commonly accepted view is that the health worker holds power and that the local women are powerless. From a Foucauldian point of view we need to look at how each has the potential to accept, challenge or ignore the perspective of the other. Even if one ignores the view of the other, the other's perspective still exists to influence what types of information are acceptable, as in the example of working with women in body mapping. Where health workers ignored or could not understand local knowledge and perceptions of women's bodies, and presented a framework from a Western medical point of view, they had the power to decide what is taught and how but, nonetheless, this did not mean that the perspective of local women had disappeared. The role of PR, then, can be to acknowledge and help differing perspectives to emerge and to strengthen participants' confidence to explore their own views.

The practical implications of the issues addressed above can be summarized as the need to search for ways in which PR can be part of an ongoing process, a process which integrates the following aspects:

- acknowledging that the power relationship between the researcher and the researched is problematic;
- identifying training needs for practitioners in PR;
- confirming knowledge produced by 'common people';
- developing a process of critical reflection on reality;
- placing the production of knowledge and action within a specific context;
- an emphasis on community action; and
- developing ways in which different interests can be negotiated by less powerful groups.

At the same time as trying to put these processes into practice it is necessary to remain aware of the problems and constraints involved. It is,

therefore, more helpful continuously to look for entry points to develop a next step, rather than to demand that the ideal be put into practice tomorrow.

Notes

1. We would like to acknowledge Beth Humphries and Margrit Shildrick for their helpful comments on this chapter.
2. The latest book of Orlando Fals-Borda and M.A. Rahman (1991) provides a useful overview of the widespread geographical and disciplinary applications of PAR and related initiatives.
3. In addition, there is a need to look at the hazardous implications of describing stereotyped at-risk groups rather than at-risk behaviour as if these groups have a collective identity. For the debate on the hazardous nature of the description of at-risk groups, see Frankenberg (1994) and Schiller et al. (1994).
4. Paulo Freire does acknowledge the feminist critique of his work in later publications. He also expressed the wish to place the critique of his earlier writings in the historical context in which they were written (Freire, in McLaren & Leonard 1993).
5. A helpful theoretical framework for examining issues around who determines need is provided by Fraser (1989). Janet Price (1992) explores the relevance of Fraser's model to Women in Development in the context of women's empowerment.

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