PIRHANA
PARTICIPATORY INQUIRY into RELIGIOUS HEALTH ASSETS, NETWORKS and AGENCY FOR HEALTH SEEKERS AND HEALTH PROVIDERS

Facilitator’s Workbook

This version of PIRHANA was developed by ARHAP (now IRHAP) in 2007. It was designed for use in a particular project focused on HIV/AIDS in an African setting – which should be taken into account when reading the manual. Since then, many different versions of PIRHANA have been developed, focusing on different issues, and with adaptations made for other contexts.

The tool is made up of theory, workshop processes and facilitation skills. This manual only presents the workshop processes. It is therefore our strong recommendation that should you be planning to run this, you should seek training or engagement from those who have previously utilized this tool.

See www.irhap.uct.ac.za  Contact irhap.mail@gmail.com

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CHAPTER 1: FOUNDATIONS FOR FACILITATION AND RESEARCH

1.1. Introduction

1.1.1. Background

PIRHANA was initially developed for work undertaken by ARHAP (the African Religious Health Assets Programme) in a research project sponsored by the World Health Organisation (WHO) to map the religious health assets of selected sites in Zambia and Lesotho in 2005/6. It is now available for use in other settings.

PIRHANA was piloted by an ARHAP team, during a week of field research in Ndola and Kitwe in the Copperbelt Province of Zambia (early November 2005). The tools were then subjected to rigorous critique by the team. Following continued reflection on field work, a second (November 2005), third (January 2006) and fourth version (February 2006) were developed for use in the WHO research. This fifth version (August 2007) integrates the lessons that we continue to learn as we undertake participatory inquiry into religious health assets. We hope that as PIRHANA is used in various settings it will continue to adapt and grow.

The key team that has developed and prepared this manual is noted on the preceding page, but through this period a number of other people have participated in the process of evaluating the tools, editing the text and making helpful suggestions.

Two significant changes are introduced in Version Five (2007). First we have shifted the titles of the two levels of PIRHANA from ‘community level’ and ‘leadership level’, to ‘health seekers’ and ‘health providers’
respectively. Whereas the previous distinction was appropriate in the context of the WHO research, it is clear that as other organisations and agencies seek to make use of PIRHANA, the latter distinction is more helpful. To this end this book makes clear the difference between the two focus groups, with chapter 4 focused on the exercises for Health Seekers and chapter 5 focused on the exercises for Health Providers. Where differences appear in the rest of the text these are noted with a thick line on the left of the paragraph. We continue to believe that a full analysis of the interaction between religion and health in a given community requires work with both focus groups, but recognise that there are occasions when it is appropriate to focus on one or the other.

The second change emerges through the wider work of ARHAP. Local communities and leadership have requested access to the PIRHANA approach and tools, to enable them to undertake their own work. It is clear that the full PIRHANA workshops require a fair deal of training and incur a range of costs, and so after deliberation, we have taken some of the key tools and re-shaped the process to have less of a focus on wider research and implementation goals, and more of a focus on local empowerment. To this end we have designed the PIRHANA-E, where E stands for empowerment. This is available in a separate workbook.

There are a number of other smaller changes to the workshop exercises in the manual, mainly as a result of having produced the WHO report. We now have a clearer perspective on the relationship between the PIRHANA workshops and the research outcomes, and this has enabled us to sharpen a number of the questions and clarify the coherence between the various exercises.

1.1.2. Training for PIRHANA

This is intended to be a practitioner’s workbook, to aid ARHAP field researchers to undertake participatory workshops around the theme of the contribution of religion to health in Africa. It is crucial that the facilitator has had basic training in (i) the ARHAP framework and theory, (ii) participatory approaches to research, and (iii) the PIRHANA approach itself. ARHAP offers this training in a number of different settings, and interested persons should make contact with the Programme.

1.1.3. Two levels of inquiry: health seekers & health providers

As mentioned above PIRHANA is envisaged to work with participants at two different levels with two suites of tools. The levels of inquiry are: (i) health providers; and (ii) health seekers. There is an important reason for this.

(a) Health Providers
ARHAP understands that religion motivates some people to offer health care, and they engage in this in various ways either individually or through various organisations. We are interested in these activities, and seek to understand the kinds of work that is done and the relationships and activities that are central to this. To understand this more fully we therefore focus on health providers.

(b) Health Seekers
Secondly, ARHAP understands that ordinary people in Africa are by-and-large religious, and that religion shapes the way that they engage in the search for health and wellbeing in a variety of ways and at various times. We are interested in how they understand the relationship between religion and health, and to ask them to identify those religious people, groups and institutions that they consider to be ‘strong assets’; and to enquire about the reasons for this judgement.

It is clear that to gain a full picture of a local or regional setting it is worth undertaking research at both levels.
1.1.4. PIRHANA-E

The first generation of PIRHANA exercises triggered off an interest in community leaders and activists wanting to use some of the tools and exercises for their own local purposes. To this end we have designed the PIRHANA-E, where E stands for empowerment. This is available in a separate workbook.

1.2. PIRHANA Approach and Aims

1.2.1. A three-fold process

It is important to recognise at the beginning that a PIRHANA workshop is the intensive mid-point in a longer and more extensive research and empowerment process. The three steps in this process can be identified as follows:

*Step 1: Preparing the workshop*
A great deal of preparation needs to be undertaken prior to the workshop. Specifically just before the workshop itself, the workshop facilitators will engage in the process of community orientation.

*Step 2: Running the workshop*
An intensive one day workshop that requires attention to the PIRHANA logic and the participatory dynamics

*Step 3: Valuing the workshop*
This involves both the outside facilitators/researchers, and the participants gaining value from the knowledge that has emerged, and making use of this in a variety of ways. (This is not to be confused with evaluating the workshop, which is a small part of step 3)

Attention will be given to each of these steps in Chapters 3 and 4. Here we now consider the wider theoretical approach that informs the whole process.

1.2.2. An overview of the PIRHANA approach

PIRHANA involves seven key elements, identified by each of the seven words

1. **Health.** We are interested in what contributes to health and healing understood in an African context as involving the comprehensive wellbeing of the interior, exterior and social body.

2. **Religious.** We are seeking to map and better understand what it is that religious entities *contribute* to health, while all the time recognising that religion can also undermine health. We understand the full contribution of religion to health as an asset.

3. **Assets.** This inquiry is focused on ‘assets’ and so locates itself in the body of work known as ‘Asset Based Community Development’, or capacity-focused approaches which recognise that ‘you cannot build a community on what people don’t have’. Thus it is looking to map what is there, rather than what is not there.

4. **Networks.** This inquiry recognises that a significant asset of religion is the networks and relationships that it fosters. A key part of the inquiry is therefore to gain an understanding of these networks (often called ‘social capital’).
5. ***Agency.*** This inquiry takes seriously that people are ‘actors’ in the field of both religion and health, and that their faith impacts upon them as they engage in both health-seeking and health-providing behaviour. A key part of the inquiry is to gain an understanding of this agency which is also understood as a religious asset.

6. ***Inquiry.*** The task involves a desire to know more, to appraise, to identify, analyse and map. The use of the term ‘inquiry’ is to make a specific link to the approach known as Appreciative Inquiry, and so the work must always seek to be empowering and not extractive.

7. ***Participatory.*** Because this is an appreciative inquiry it is highly participatory; but this word also signals a link to the approach known as Participatory Rural Appraisal, or Participatory Learning and Action (PRA/PLA) – and therefore is rooted in the idea that participatory work involves ‘handing over the stick’, so that local people drive the inquiry and have ownership.

### 1.2.3. Logic and coherence

The PIRHANA workshops have been developed in a coherent and logical manner, and the participatory exercises are designed to generate knowledge progressively through the exercises. Owing to the difference in exercises between health seekers and health providers, attention will be given to this when the workshops are introduced.

### 1.2.4. The aims of PIRHANA

PIRHANA has been designed with five clear aims in mind:

1. The participatory approach recognises that the knowledge, wisdom and information that is generated in the research process belongs primarily to the local community. By undertaking the research in a respectful and appreciative manner, the research seeks to empower the agency of local communities in action and advocacy for health and wellbeing. The workshops always end with a specific exercise aimed at local action and commitment.

2. To make Religious Health Assets visible for policy makers in the fields of both public health and religion. By undertaking a participatory process that asks certain questions of health seekers and/or health providers, a range of religious entities that contribute to health and wellbeing are identified and examined, and ‘mapped’. This provides important information for those involved in health planning.

3. Especially where the information is drawn from a number of cross-site workshops, the PIRHANA process is a step that can lead into what we call ‘leadership engagement’. This is a process whereby the information that is generated in the research can be utilised by leaders so that the existing Religious Health Assets can be leveraged in new and exciting ways.

4. The PIRHANA process seeks to generate new theoretical understanding ‘from the ground up’ about religion and health in an African setting. ARHAP is committed to a Grounded Theory approach to these wider questions, and this research process contributes directly to this.

5. Finally, by seeking to meet these four aims, PIRHANA contributes directly to the wider aims of ARHAP.
ARHAP seeks to develop a systematic knowledge base of religious health assets (RHAs) in Sub-Saharan Africa to align and enhance the work of religious health leaders, public policy decision-makers and other health workers in their collaborative efforts to meet the challenge of disease such as HIV/AIDS, and to promote sustainable health, especially for those who live in poverty or under marginal conditions.

1.3. Participatory research

1.3.1. Theoretical background

PIRHANA has a broad theoretical ‘DNA’, which can be briefly summarised in the following way, (those who are interested are encouraged to explore these terms in greater detail).

- Participatory Rural Appraisal
- Appreciative Inquiry
- Local (African) insights into the Religious
- Contribution to Health
- Asset Based Community Development
- Networks in Social Capital theory
- Agency of ordinary people

1.3.2. Local people are experts

The fundamental reason for a participatory approach is that in work to do with Religious Health Assets we are seeking to find the connections between religion and health in an African context. We are entering a field that has only recently begun to be explored, and we are doing it in dialogue with ordinary people in a range of communities in Africa. To this end, we need the help of local people who are the experts, and we need to find ways of opening up discussion and reflection so that we are helped, and in the process the participants feel stronger and motivated.
In these circumstances, Robert Chambers’ reflection on Participatory Rural Appraisal in *Rural Appraisal: Rapid, Relaxed and Participatory*, (IDS discussion Paper 311, University of Sussex, 1992) is worth quoting in full:

The core of good PRA is our behaviour and attitudes. It involves:

- Being self-aware and self-critical
- Embracing error
- Handing over the stick
- Sitting, listening, adapting
- Using our own best judgement at all times

So we can ask:

- Who lectures? Who holds the stick? Whose finger wags?
- Whose knowledge, analysis and priorities count?

Ours? Theirs, as we think they should be? Or theirs as they freely express them?

Good PRA is empowering, not extractive

Good PRA makes mistakes, learns from them, and so is self-improving

Good PRA spreads and improves on its own

So START. Do not wait. Get on with it. Relax. Try things. Learn by doing. Fall forwards. Experiment. Ask – what went well? What went badly? What can we learn? How can we do better? How can we help others to do better?

Remember the three pillars:

![Diagram of three pillars: Behaviour & attitudes, Methods, Sharing]

**1.3.3. Behaviour and attitudes**

It is crucial then that when we engage in a participatory inquiry (such as PIRHANA), we are conscious of our behaviour and attitudes. While we are tasked with finding information that meets our research objectives, we must constantly remember the wider ARHAP concern to deliberately avoid an extractive research approach, and at all times to ensure that all knowledge and insights are ‘owned’ by the people who have offered them in the participatory setting.

In the same text, Chambers writes of the key principles of behaviour and attitudes in PRA:

*Facilitating – they do it:* facilitating investigation, analysis, presentation and learning by rural people themselves so that they present and own the outcomes, and also learn. This has been expressed as ‘handing over the stick’ (or pen or chalk). This often entails an outsider starting a process and then sitting back or walking away and not interviewing or interrupting.

*Self-critical awareness and responsibility:* meaning that facilitators are continuously examining their behaviour, and trying to do better. This includes embracing error – welcoming error as an opportunity to learn to do better; and using one’s own best judgement at all times, meaning, accepting personal responsibility rather than vesting it in a manual or a rigid set of rules.
Sharing: of information and ideas between rural people, between them and facilitators, and between different facilitators, and sharing field camps, training and experiences between different organisations. All of this reflects issues of power, and power lies at the heart of participation, research, information and knowledge. We need to be very conscious of all of this as we embark on PIRHANA, and be attentive to our attitudes and behaviour in the context into which we are going. It is for these reasons that ARHAP is very clear that the PIRHANA process should be conducted by those who have received training in the approach.

1.4. PIRHANA as a research tool

1.4.1. Participatory methods

PRA makes use of a great many methods and tools. These include such things as:

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<th>Participatory mapping</th>
<th>Timeline and time trends</th>
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<tr>
<td>Transect walks</td>
<td>Biographies</td>
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<tr>
<td>Wealth rankings</td>
<td>Local histories</td>
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<tr>
<td>Venn diagramming</td>
<td>Network diagrams</td>
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<tr>
<td>Seasonal calendars</td>
<td>Livelihood/Household system diagrams</td>
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<tr>
<td>Matrix scoring and ranking</td>
<td>Pie charts</td>
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<td>Process/Flow diagrams</td>
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PIRHANA has drawn on these kinds of exercises and adapted them. It words with both health seekers and health providers making use of the following participatory methods:

- **Participatory mapping** in which participants map their communities, identifying the existing social and religious entities.
- **Participatory diagramming** in which participants produce diagrams of the relationships between religious and health entities.
- **Participatory indexing** in which participants create their own collective definitions of key factors to do with religion, health and wellbeing.
- **Participatory ranking** in which participants rank the relative strengths and weaknesses of the religious contribution to health and wellbeing.

These exercises are broadly designed to elicit the following information:

- Increased understanding of religion and religious entities, as religious health assets, in the local area/context
- Perceived strengths of the assets
- Ties and connections between identified assets
- Changes of scale, order or character taking place among the assets
- Capacity challenges in relation to the community at large
- Actual use of the assets by people on the ground
- Deeper dynamics in the choices people make about religious health assets, as a crucial contribution to understanding what maps at a more general level mean in practice, especially in local communities where policies must be implemented

The PIRHANA tool is applicable in a variety of settings, both urban and rural. Special care must always be taken to ensure translation and adaptation to the local context.
1.4.2. The participatory research process

It should be evident that the PIRhana research process is an empirical study driven by a participatory, inductive and non-extractive approach. This has an important impact upon the generation of research data in three ways.

- The discussion about religion and health is, by and large, generated ‘from below’, as participants reflected upon these issues in their own context. It is possible to introduce a specific issue or questions – such as TB, AIDS or violence – in the form of a question into the discussion, but care must be taken to avoid turning the workshops into interview sessions.

- The generation of research data is uneven across research sites. The use of group-identified factors in the exercises will generate data that is highly context-specific. While this has its obvious weaknesses for quantitative research purposes, considered in full, it is the extraordinary strength of this research theory and method. Given the state of knowledge about RHAs at this point in time, this is a significant boundary that needs to be interrogated.

- The attention given to participation both at the content and process levels means that at times, participants can take hold of discussions and steer them in their own directions. Keeping a hand on this requires both (i) sensitive respect for the participants and (ii) attention to the stated research goals on the part of the research team. We are aware that at times there can be tensions between these two objectives and that this also has a bearing on the nature of the research findings.

1.4.3. The nature of the research findings

The PIRhana exercises are designed to uncover the perceptions of the participants about the relationship between religion and religious entities on the one hand, and health, healing and wellbeing on the other, and to do so in a public manner.

(a) Qualitative data
‘Perceptions’ is the key word, and it is important that those undertaking the research are aware that they are not getting cold objective ‘truth’ (if there is such a thing!), This means that we are getting primarily qualitative data, and we are dealing by and large with the opinions of those who happen to be present in the workshops. However, PIRhana goes beyond just qualitative research.

(b) Quantitative data
The benefit of the kind of participatory exercises used in PIRhana means that these perceptions are quantified, and that at the end of most exercises we end up with quantitative data in the form of lists and rankings that enables us to compare and contrast across sites, and to slowly build up an understanding of religious health assets in Africa.

(c) Transparent data
One extremely exciting thing about a participatory approach to data collection is that this takes place in a transparent manner. While we are dealing with the perceptions of the participants (as noted above), this is done in an openly peer-reviewed manner where these perceptions can be tested and moderated. Because they are subject to open public scrutiny this helps to ensure that what PIRhana is identifying is ‘common knowledge’ shared by those on the ground, rather than ‘weird, wonderful and off-the-wall opinions’ of a few isolated individuals.

(d) Democratic data
The PIRHANA exercises are generally designed to ensure the democratic participation of each participant, so that in most exercises each person has the same ‘power’ to share ideas and insights. Generally in qualitative research workshops such as focus groups, the ideas and opinions of powerful individuals in the community can predominate. These exercises are carefully designed to avoid this, although it cannot be avoided altogether and facilitators need to be aware of this all the time – particularly gender and age discrepancies.

(e) Interpreted data
A further exciting thing about PIRHANA is that the public nature of the exercises means that it is easy to move from the data itself to the interpretation of the data, so that as outsiders we are not left in the dark about what the data means but can test it immediately with the participants. So, for example, when a certain factor is strongly identified in a certain workshop, it can lead to a open – and usually energetic - conversation.

(f) Appreciated data
The beauty of the PIRHANA workshops is that wisdom and knowledge that is ‘just known’ by participants is exteriorised via the exercises and presented in visual manner through things such as time-lines, indices, ranking matrices, and spidergrams; and then once it exists in an ‘objective’ form, it can be explored in greater detail. In this way participants see and experience their opinions and perceptions being appreciated and taken seriously.

(g) Empowering data
The data that emerges in the workshops is open, transparent and public. It belongs to the group in a very immediate and obvious way, and the appreciative approach enables communities to recognise and acknowledge the wisdom and capacity - the assets - that they have. The workshops always end with an exercise focused on ‘local commitment’. This reminds us that the first aim of the tool is to empower the agency of local communities in action and advocacy for health and wellbeing (see 1.2.4.)

1.4.4. Participant selection: stratified purposive sampling
The quality of data that emerges from the PIRHANA research process hinges on the quality of the facilitation, the selection of the participants, and a research process that is ethically correct. The technical aspects of this selection, and accompanying research ethics is dealt with in greater detail below. Here we need to note that in terms of research methodology, the PIRHANA process makes use of stratified purposive sampling, which brings together key informants who are representative of important sub-groups in the study population, and these are generally identified through a snowball process.

1.5. Research ethics
PIRHANA involves participatory research with human subjects, and it is possible that issues to do with illness, vulnerability and death may be raised. It is crucial that facilitators are familiar with research ethics governing research with human subjects and vulnerable people. This is a further reason why this may only be undertaken by trained PIRHANA facilitators.

1.5.2. Formal ethical clearance
Any research undertaken with human subjects should gain ethical clearance from the appropriate body or bodies. This may be a University, a state medical research council, or other such regulatory body.
1.5.2. Clarity of research expectations

It is crucial that at the time of invitation participants are informed that they are participating in a research programme, that they understand the meaning and implication of the research, and that they consent to being involved, to having their ideas used by others, and to having their photographs taken and used in reports.

It is important that the letters of invitation state clearly that the meeting is to undertake research and to learn from the participants, rather than primarily for outside research people to teach or to promote something (which is the default expectation). Such letters of invitation should also clearly explain what ARHAP is and is seeking to do, and provide contact numbers for people to follow up information. At the workshop, an information sheet with contact numbers should be made available to participants (see below).

1.5.3. Clarity of participant expectations

It is crucial that the research team clarify its own expectations around a number of issues and communicate these clearly to the participants prior to the meeting. These include:

- *Food and refreshments* – as the workshop takes a full day it is recommended that at least lunch and drinks are provided.
- *Refunds for transport* – this will depend on whether people are expected to use transport.
- *Research report* – clarify what part of the research will be passed back to participants from both a practical and an ethical perspective.

1.5.4. Safe storage of data

Participants need to be informed that unless specific permission is requested, all research data is anonymous and will be safely stored separately from registration forms.

1.5.5. Consent form

After the welcome and introduction to ARHAP and the research process, participants are asked for their consent through signing a consent form.

It is important that all team members are aware that photographs and recordings should not be made in the early stages of the workshops, prior to the signing and collection of consent forms.
1.6. PIRHANA with a special focus

A major reason why ARHAP is interested in auditing and aligning religious health assets is so that they can contribute to the struggle for life in the midst of various health crises and epidemics. Apart from a general concern, a given PIRHANA process may have a special research focus such as TB, HIV/AIDS, or violence against children.

1.6.1. Health seekers

With health seekers it is important that we do not ‘force’ the issue in a communal setting, owing to a range of sensitive issues to do with disclosure, stigma and local sensitivities in a setting where neighbours and local religious leadership may be present.

One of the aspects of the participatory process is to allow the issues to emerge inductively within the wider discussion about religion and health. Our overwhelming experience is that ordinary people are quite perceptive, and if they are able to trust the appreciative attitude of the facilitators and the creative space to reflect about health in the community they will intuitively connect with important issues in the community. If they do not sense this trust, no matter how much is asked about a specific issue, people will usually just give the answer that they think the facilitator wants to hear.

Thus at the local level with health seekers from the community, it may well be that the facilitator will have to ‘naively probe’ on certain occasions to clarify terms and words that people are using so that the appropriate insights can be recorded. At the same time there may be appropriate times to pose a specific question specific to the research focus. Once again this points to the importance of trained facilitators leading the process.

1.6.2. Health providers

The situation amongst health providers will in all likelihood be quite different as many of the participants will be invited because they are specifically involved in responsibilities to do with the special focus. Here more specific questions can be asked.

1.6.3. Intentional reflection during debriefing

It is crucial that the research team ‘debrief’ at the end of a PIRHANA workshop. Where there is a specific research focus, it is important to be intentional about issues relating to this focus, as insights and connections which may not be made by participants during the workshops could be identified.

1.6.4. Information about local HIV and AIDS centres

It is possible that concerns about HIV and AIDS or other life-threatening diseases will be raised in the workshops. Therefore, it is essential that facilitators arrive at the workshop with information (including contact details) of local information or health centres, so that this accurate information can be passed on to participants.
CHAPTER 2:
ORIENTATION TO ARHAP CONCEPTS
AND IDEAS

2.1. Introducing ARHAP

ARHAP is made up of five words, and each one is a helpful way into this introduction.

2.1.1. Health

We start with health because it is the formal context in which we are working, researching and reflecting. This means three things:

1. By health we mean public health. We are not focusing on individual health and its relationship to individual religion such as in forms of the New Age movement. We are focused on a broader sweep of issues to do with health policy and practices which impact upon society as a whole.

2. And as we focus on public health we are consciously locating that within the world of political policy, economic power, and cultural and social forces which shape the way that society is structured and which have a definitive impact upon the health of citizens.

3. We are convinced, for a variety of theological and development reasons, that the health of the people, and particularly the health of women and children, is the most appropriate indicator of the health of a society – rather than the size of the economy or the GDP, or household income.
2.1.2. Africa

ARHAP began with a global focus, and there is no reason why this work does not apply elsewhere. However, at present we are a team of African-lead and African-engaged academics. Our work is located in Africa, and this gives it three important foci:

1. The context of Africa is the context of her children being the victims of a 500 year story of slavery, colonialism, imposed development programmes and structural adjustment. Health is deeply located in this current context of poverty, violence, forced migration, and environmental destruction.

2. At this present time, and specifically in terms of health, the context of Africa is also the context of HIV and AIDS – and this provides the dramatic coalition of issues of politics, economics, environment and public health. It is the constant backdrop of our work.

3. Within this context Africa offers its own deep and powerful insights and resources in terms of health – including its languages which understand health in a broader sense of ‘wellbeing’, its traditional religious holistic frameworks, and its deeply committed people who are agents of transformation in the most difficult of circumstances.

2.1.3. Religious

ARHAP locates itself at the intersection of religion and health. We are focused on the way that religion impacts upon health in Africa. For us this means:

1. That we are consciously inter-religious, and not just Christian. We are seeking to draw together and engage with a variety of traditions, respecting them and what they are doing already – rather than seeking a normative or prescriptive model of what is to be done.

2. We are very conscious that in a world where the dominant paradigm for public health policy emerges from the secular west, that religion is often not taken into account. But we are very conscious that this is a great weakness in Africa where religion is such a powerful factor in people’s lives.

3. And we are particularly aware that in Africa, religious groups and institutions provide somewhere between 30 and 70% of all public health facilities. This is something that provides the solid base for our work – but also the challenge, because so little has been done to document and understand this.

2.1.4. Assets

Prominent in the name, ARHAP, is the word Assets. What does this mean?

1. It means, first, that we are rooted in an asset-focused approach to transformation, believing that we ‘cannot build a community on what people do not have.’ This is a fundamental attitude that begins with what exists, what is positive, what brings life, what makes people proud.

2. We are interested, then, in what religious groups have and offer in the struggle for health and for life. We are focused on the obvious tangible assets like mission hospitals and church dispensaries, but also on the intangible things that religion offers such as hope, trust, relationships, teaching, networks, prayers, and ethical frameworks.

3. A crucial thing about assets is not just that they exist, but that they need to be mapped and understood, and then they need to be aligned with one another because it is in the coherent joining of assets that we are able to build a healthier world.
2.1.5. Programme

And so that brings us to the fact that this is not just an idea, but is a research programme that is underway in a number of Southern African countries – such as Zambia, Lesotho, South Africa, or Zimbabwe – and that has inspired similar reflection in East Africa, Europe and North America.

1. It is a participatory programme. Everything we have been engaged in takes very seriously the relationship between religion and power. We are seeking to hear from people on the ground, and to do so in such a way that the knowledge and insights that are generated are available to and are owned by local people and leadership.

2. It is a theoretical programme that is seeking to find the language and frameworks to understand this interrelationship between religion and health in Africa. This in a world in which religion is usually understood as an epiphenomenon rather than as a crucial element.

3. It is also an advocacy programme, that it is drawing together knowledge and theory in order to make a difference in the world. ARHAP wants to use this information to impact upon policy formulation for both the religious and the public institutions. We want ultimately to contribute to a healthier world.

2.1.6. Summary

In a time of HIV and AIDS, of deteriorating public health facilities, and of internal political struggles in Africa – we are committed to finding out ways in which religious agencies, people, networks and institutions – what we have called ‘assets’ - can make a difference.

1. To do this we need a greater understanding of what religious ‘assets’ already exist, how they work, and how they can be aligned to become more effective.

2. We need also to think of news ways of conceiving health policy in Africa, in frameworks that take this religious contribution seriously.

3. And finally we need to draw upon the energy that drives religious people and entities forward, to constantly engage this theoretical work in practical action.

2.2. Defining the ARHAP Lexicon

As with all emerging fields, nomenclature and definition of terms are critical to understanding, replicability, and interpretation of results. Out of previous research using PIRHANA, we have found that the following terms are worth understanding as they are beginning to constitute a new ‘lexicon’ of Religious Health Assets, Networks, and Agency.

2.2.1. Religion

Religion: A wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralized to decentralized, communal to institutional. In Africa, this includes particularly African
traditional religions, Islam, Christianity and generally a wide variety of other identifiable religious formations.

**Healthworld**: Neologism for *bophelo* (Sesotho), *impilo* (isiXhosa), *ubumi* (Bemba) and other African linguistic equivalents, but expressed as a concept argued to be of general significance. Refers to peoples’ conceptions of health, as framed by the background store of inherited or socialized knowledge that defines their being in the world. A person’s healthworld expresses and guides healthseeking behaviour, choices and actions, in respect of illness or dysfunction in health, towards a telos of comprehensive well-being. Culturally and linguistically constituted, spiritual and corporeal, it addresses the condition of the whole body - understood as the ecology of the individual body in relation to the social body under particular material conditions - and thus includes the social and environmental determinants of health.

**Bophelo**: A Sesotho word, bophelo has a rich lexical range. Its meanings range from biological life (of humans, animals and plants) to the social life of individuals, families, villages and countries. Religion and health are an integral and integrated dimension of the social dimension of bophelo.

### 2.2.2. Religious entities

**Religious Entity (RE)**: The term ‘religious entity’ seeks to capture the broad range of religious institutions, facilities, organisations and initiatives, as well as self-standing individual practitioners, both bio-medical and traditional, found in Africa. This encompassing term is necessary in order to be able to speak of more regular religious entities such as faith-based organizations, as well as those more amorphous entities such as individual traditional healers, each of which might offer identifiable health services or support. Where these REs are involved in health work, they may be understood as (tangible) Religious Health Assets (see below). The following are some of the key REs that are identified in this report.

**Faith-based Organization or Initiative (FBO/I)**: Faith-based organizations are those religious entities that have a more structured nature as well as religious support. This includes organizations tied to religious groups (such as mission hospitals or faith-based CBOs and NGOs); as well as community networks. We add the term ‘initiative’ to refer to identifiable, significant work in health that is not yet formally organized but may exist for some time through loose arrangements, often the early phase of a formal organization and not uncommon for religious leaders.

**Church**: Aware of the problematic issues surrounding the use of the word ‘church’, especially in inter-religious writing, we use this term as sparingly as possible. However, in the context of this research, the term has occasionally been used to indicate Christian denominational structures at a regional/national/international level. For example, a regional collective of congregations of the same nature would be a church - or in terms of such denominational structure as ‘The Catholic church’ or ‘The Anglican church’.

**Congregation**: A locally organized religious or faith-based entity, meeting regularly for specifically religious purposes, whose primary function is the formation of faith. This term is not intended to indicate only Christian groups but is used to signify all such gatherings of any faith.

**Traditional Healer**: This is a complex typology, and is differently constituted in different contexts in Africa. However, for the purposes of this report, we indicate here three types of indigenous health providers, or traditional healers, in Lesotho and Zambia which are constituted by (i) Diviners, (ii) Herbalists and (iii) Zionist/Apostolic healers. Some herbalists distinguish themselves as working solely with herbal remedies. Diviners practice on the basis of engagement with ancestral and spirit forces, and other diviners are also Zionist/Apostolic priests. The three ‘types’ must be understood as operating on a complex continuum.
2.2.3. Agency and assets

**Agency:** The capacity to ‘do’, to move into action, to utilize the assets one has, to seek and achieve desired goals, as affected by social and environmental conditions. In the context of dramatic health challenges such as HIV/AIDS (and conditions of poverty), human communities have assets and the capacity to exert agency. Agency rests within individuals, but even more so in communities, organizations. The common assumption that poor people are ‘not able to do’ is untenable. Poor people are always engaged in strategies and struggles for survival, adaptation and freedom.

**Asset:** This term refers to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation. Assets carry value and may be leveraged to create greater value. Beginning with assets is to set aside the dominant approaches that begin with needs or deficits, so as to make local agency more clearly visible. Needs, by contrast, imply that we are seeking to identify and overcome what is found to be lacking. Another common concept, resources, as distinct from assets, is more passive; they are there to be used rather than leveraged and grown. An asset-based approach takes as its starting point the concern that people and their communities should be viewed as having assets, which can be effectively mobilised or leveraged in order to empower communities, rather than viewing them in terms of deficits, which hamper their development.

**Religious Health Asset (RHA):** A religious health asset is an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The notion of RHAs captures the fundamental idea that assets carry value and may be leveraged for greater value. If they are not used, then they remain at rest, but always available for use through some agentive act. We are also using the term broadly to encompass any religion or faith; particularly we include here those assets typical of African traditional religions.

**Tangible and Intangible Assets:** The more obvious, and most studied RHAs are those which are tangible, i.e. facilities and personnel, acts of caring and compassion, and material support or curative interventions, most of which appear identical to secular entities. Underlying this tangible level, however, are the volitional, motivational and mobilising capacities that are rooted in vital affective, symbolic and relational dimensions of religious faith, belief, behaviour and ties. Local knowledge, access, reach, participation, trust, hope, resilience and accompaniment are just some of these ‘invisible’ or what we prefer to call intangible religious health assets.

**Relationship between REs and RHAs:** Not all Religious Entities (REs) are tangible Religious Health Assets (RHAs), and not all tangible RHAs are REs. Insofar as REs are engaged in health work, they are considered to be tangible RHAs. On the other hand, tangible RHAs include REs, but also include a range of other tangible religious health assets such as caring and material support. Furthermore, what this research has shown is that REs themselves embody a number of intangible health assets.

2.3. Bophelo – Health in an African world

*By Sepetla Molapo and Paul Germond*

Preliminary ARHAP findings from work in Lesotho showed that the words religion and health limit an inquiry into the interface between religion and health in an African context. This is because both words issue out of a Western classification system that assumes a neat and clear distinction between the realm of religion and spirituality and that of health and the physical body. Within an African context these categories are complicated by an absence of a neat and clear distinction between religion and health. This is true for Lesotho as well as others cultural locations. Further work, as a consequence, needs to be done on other African contexts.
In Sesotho, as both the language and culture of Basotho, the words religion and health are intertwined and do not bear any distinguishable boundaries. In fact, in Sesotho these two words find expression within the perimeters of what Basotho call *bophelo*. At its most basic, *bophelo* refers to biological life. Thus animals and humans possess bophelo. At an intermediary level, bophelo is social life and is granted by the community. At its highest level, bophelo is a vision of a utopian life. It is a vision of a perfect life that people aspire to. Here, both health and religion are integrated into the experience of bophelo. In the Sesotho worldview, bophelo is found and expressed in a diversity of socio-spatial configurations in which *motho (a person)* is the primary focus. The most basic of these is *lelapa (a homestead)*. It is within the framework of lelapa that the elements that constitute bophelo are organized and located. Examples of these are food, reproduction, instruction, love, neighbourliness, etc. It is the primary responsibility of malapa (homesteads) to ensure proper nourishment and socialization of batho (persons). Following lelapa is the socio-spatial configuration of *motse (a village)*. Motse forms an extension of lelapa and is therefore a conglomeration of malapa (homesteads). Thus motse is expected to carry the same functions of lelapa and nourish and socialize motho (a person). It is no wonder then that in the Sesotho world-view every adult man and woman is regarded as a parent and is expected to act as a guardian to all children in the village. What distinguishes motse from lelapa are shared public service institutions and infrastructure. Examples of these are post-offices, shops, schools and running water. A village that has these facilities is considered to have more bophelo than one that lacks them.

Thus motse is expected to carry the same functions of lelapa and nourish and socialize motho (a person). It is no wonder then that in the Sesotho world-view every adult man and woman is regarded as a parent and is expected to act as a guardian to all children in the village. What distinguishes motse from lelapa are shared public service institutions and infrastructure. Examples of these are post-offices, shops, schools and running water. A village that has these facilities is considered to have more bophelo than one that lacks them.

Both malapa (homesteads) and metse (villages) find expression within a framework of what Basotho articulate as *naha*.

Naha refers to two key constitutive elements in the socio-spatial configurations of bophelo. Firstly, naha designates the *land*, a place where cattle are nourished (the *veld*) and masimo (*fields*)which provide nourishment for persons within malapa and metse. Secondly, it designates the land within political boundaries (ie the *nation*). Without the land there can be no bophelo. Generally, the land is understood to be a possession of *badimo (the ancestors)* who act as guardians of malapa and metse. This entire social world is therefore legitimated by badimo whose existence is intrinsic to understandings of bophelo. In this context then, health is integral to all aspects of life. It cannot be reduced simply to the health of the individual; it encompasses every facet of life. By the same force, health is relational. The existence of good relations between the different dimensions of society is integral to the extent of health in a given community.

<table>
<thead>
<tr>
<th>English</th>
<th>Sesotho</th>
<th>Bemba</th>
<th>isiZulu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person/individual</td>
<td>motho</td>
<td>umuntu</td>
<td>umuntu</td>
</tr>
<tr>
<td>family/homestead</td>
<td>lelapa</td>
<td>ulupwa</td>
<td>ikhaya</td>
</tr>
<tr>
<td>Village</td>
<td>motse</td>
<td>umushi</td>
<td>umzi</td>
</tr>
<tr>
<td>Land</td>
<td>naha</td>
<td>ichalo</td>
<td>ilizwe</td>
</tr>
<tr>
<td>ancestors/spiritual world</td>
<td>badimo</td>
<td>ifikolwe</td>
<td>amadlozi</td>
</tr>
</tbody>
</table>
CHAPTER 3: PREPARING, FACILITATING AND VALUING A HEALTH PROVIDER WORKSHOP

3.1. A three-fold process

We noted at the start that a PIRHANA workshop is the intensive mid-point in a longer and more extensive research and empowerment process (see 1.2.1.). To repeat, the three steps in this process can be identified as follows:

Step 1: Preparing the workshop
A great deal of preparation needs to be undertaken prior to the workshop. Specifically just before the workshop itself, the workshop facilitators will engage in the process of community orientation.

Step 2: Running the workshop
An intensive one day workshop that requires attention to the PIRHANA logic and the participatory dynamics

Step 3: Valuing the workshop
This involves both the outside facilitators/researchers, and the participants gaining value from the knowledge that has emerged, and making use of this in a variety of ways. (This is not to be confused with evaluating the workshop, which is a small part of step 3)

We turn now to explore each of these in greater detail.

3.2. Preparing the workshop: an overview

Experience has suggested that setting up a PIRHANA health provider workshop usually requires eight crucial steps, some of which need to be happening at the same time.

3.2.1. Identify three key people

A team is needed for the workshop itself, but in the preparatory stages three key people are necessary.

(a) Senior investigator.
The PIRHANA research process needs a Senior Investigator who is responsible for the overall shape and budget of the research project. This person needs to understand the philosophy and logic of the ARHAP process, and is usually the one who initiates the process.

(b) Research officer
It is vital to engage a research officer who is a person with excellent people- and organisational skills, and who understands the philosophy and logic of the PIRHANA process. This person needs to have the time and budget to visit a location, thoroughly appraise him or herself with the local situation, make important contacts, share the vision of ARHAP research vision, gain the necessary permission, and seek out the appropriate stake-holders to attend the workshop. Language and cultural capacity is significant. This person will then continue to play an important role in the workshop team itself.

(c) Local contact person
A crucial issue in the success of the workshop is making contact with a local role-player who is trusted and respected by local people – both community members and community leadership. This might be a district co-ordinator of health, a bishop, a doctor, nurse or a pastor. Local experience and knowledge is absolutely vital for this process, and it is clear that the PIRHANA process is dependent upon this. The ability to invite the right people to the workshops is hugely dependent upon this.

### 3.2.2. Clarify research objectives and constraints

Before any practical preparations can be put in place the PIRHANA team must pay attention to the following:

1. You must have a clear research objective in mind, who the target community is, and which local leadership and/or organisations can provide leadership in the process. This is particularly important in terms of local commitment, as the process that is initiated by the workshop needs to continue in some way afterwards.

2. Contact the relevant authorities and receive research and ethics clearance. This is a key role for the Senior Investigator.

3. It is also important that local leadership is aware of the workshop, even if they are not specifically invited. This might mean a courtesy call to the local mayor, chief, district administrator, member of parliament, or religious official. Given that the long-term objective is to influence public policy, it is culturally, ethically and strategically important to make such leadership aware of what is happening.

### 3.2.3. Prepare a budget

Consider the financial constraints. Identify what can be expected to be achieved within the budget. Each of the three steps involves financial commitments.

1. Preparation.
   1.1. Research officer: transport, accommodation, food, toiletries, telephone costs,
   1.2. Workshop assistants: telephone costs, stipends, transport, food
   1.3. Venue costs: deposit for booking
2. Workshop expenses
   2.1. Research team – transport, accommodation, food.
   2.2. Venue costs
   2.3. Catering
   2.4. Transport fees for participants
   2.5. Equipment and stationery
3. Valuing and analysing the research
   3.1. Research team to meet and analyse data – transport, accommodation, food
3.2. Costs for investigators’ time to analyse
3.3. Final preparation, editing, printing, distribution of research findings.

3.2.4. Make practical arrangements

Prior to the workshop it is important to undertake the following practical arrangements:

1. Identify the date, day and month when the study will be carried out. The days chosen must be in line with the availability of community members and facilitators.

2. Book a suitable venue for Health Seekers: It must be accessible and spacious enough, allowing for the full range of workshop exercises. At the same time, a PIRHANA with ordinary people who are health seekers needs to be undertaken in a local community setting such as a church hall, mosque, municipality hall or clinic. Chairs, shade, open floor space, and walls are important. Be careful not to create the impression of being too sophisticated and unappreciative of local ‘assets’

3. Organise food for Health Seekers. Meals should be served on time so as not to disrupt the workshop programme. The person doing catering must have been informed ahead of time to serve meals promptly.

4. Book a suitable venue for Health Providers: It must be accessible and spacious enough, allowing for the full range of workshop exercises. It should preferably be a neutral venue in a central location with lunch provided on the premises. Ensure that the venue can cater for the food requirements of participants (i.e. halal/kosher).

5. Acquire all the workshop materials. A full list is provided below.

6. Make sure that all the documentation for the workshop is prepared. This will include consent form, information sheets, and any technical forms you would like them to fill in. Prepare newsprint and workshop materials beforehand.

7. Consider issues of translation, and it may be important to work with a competent translator. He or she should have access in advance to the crucial research questions that are to be asked. It will be helpful to have these written out on newsprint for the various exercises so that they can be asked clearly and precisely.

3.2.5. Identify the participants: stratified purposive sampling

Through a snowball process the Research Officer and local contact person identify key persons in the community and begin to share the study objective(s) as well as the aims of ARHAP and PIRHANA. Such persons must have competent knowledge of the area, language and community life.

This wider group then begins to brainstorm who the possible attendees could be, bearing in mind the principles of stratified purposive sampling.

The workshop will work best with between 20 and 30 people, with a good mix of male and female, elders and youth, with different religious affiliation and health interests (where possible). While bias can never be fully avoided, it is crucial that the PIRHANA facilitators take care with the invitations to ensure broad-based participation and non-domination by a certain segment of the community. It is suggested that attention be paid to: religious diversity, Christian denominational diversity, public health officials, leadership of significant NGOs and health formations. Because of this, it is not helpful to hand over the responsibility of inviting participants to a third party.
To help with the balance it is sometimes helpful in some of the exercises to include the questions: ‘who else should have been here?’ and ‘would they have told us different things? If so, what?’

### 3.2.6. Invite the participants

Write invitation letters to those persons you identified as potential attendees. The following should be indicated in your letter of invitation:

1. The invitation letter should bear a letterhead of your organisation. It should include basic information about ARHAP and the research project. It must provide a contact person for queries and confirmations.

2. State the venue with a clear physical address, the date and time. Clearly state the duration of the workshop. Clearly state if you provide lunch and transport refunds and note the general profile of your attendees.

3. Letters should be personalised, and follow any community or religious protocol. They should also ask people to state their food preferences when they reply.

4. Letters should be hand-delivered to ensure they were received.

It is important re-confirm that those invited are still coming and that they remember the day of the workshop.

### 3.2.7. Acquire the equipment

1. **For Health Seekers** the following equipment is necessary:

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration list</td>
<td>Form for people to fill in when they register (see 5.8 below)</td>
</tr>
<tr>
<td>Consent form</td>
<td>1 form per person</td>
</tr>
<tr>
<td>Marker pens</td>
<td>32 (at least one per participant, in a range of colours)</td>
</tr>
<tr>
<td>Newsprint</td>
<td>50 sheets</td>
</tr>
<tr>
<td>Masking tape</td>
<td>2 rolls</td>
</tr>
<tr>
<td>Index cards</td>
<td>250 cards (102 x 152mm)</td>
</tr>
<tr>
<td>Beans</td>
<td>A large bag of sugar beans or white beans (need min of 1000)</td>
</tr>
<tr>
<td>Bean holder</td>
<td>It is useful to have a number of bean holders so that different people can ‘control’ the beans</td>
</tr>
<tr>
<td>Tape recorder</td>
<td>1 with decent microphones to pick up discussion</td>
</tr>
<tr>
<td>Camera</td>
<td>For recording of exercises</td>
</tr>
<tr>
<td>ARHAP Poster</td>
<td>For introducing ARHAP</td>
</tr>
<tr>
<td>Filing box</td>
<td>A box to store the completed forms, as well as newsprint etc.</td>
</tr>
<tr>
<td>Rubbish packets</td>
<td>To keep the meeting space clean</td>
</tr>
<tr>
<td>Refreshments</td>
<td>Lunch and cool drinks or water (Be attentive to the dietary requirements of the representatives of different religions)</td>
</tr>
<tr>
<td>Money</td>
<td>Transport money in correct cash amounts in envelopes</td>
</tr>
</tbody>
</table>

2. **For Health Providers** the following equipment is necessary:

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration list</td>
<td>Form for people to fill in when they register (see 6.8. below)</td>
</tr>
<tr>
<td>Consent form</td>
<td>1 Form per person</td>
</tr>
<tr>
<td>Name tags</td>
<td>1 per participant and member of the research team</td>
</tr>
<tr>
<td>Marker pens</td>
<td>32 (at least one per participant, in a range of colours)</td>
</tr>
</tbody>
</table>
Pens | Box of cheap pens
---|---
Newsprint | 30 sheets
Maps | A3 size printed maps of the area under consideration
Masking tape | 2 rolls
Envelopes | 40 for transport reimbursements
Stapler | 1 to create information packs
‘Post-it’ notes | 4 packs per day – 4 different colours would be helpful
Tape recorder | 1 with decent microphones to pick up discussion
Camera | For recording of exercises (plus spare batteries)
ARHAP Poster | For introducing ARHAP
Data box | To keep the data from the workshop secure.
Filing box | A box to store the completed forms, as well as newsprint etc.
Rubbish packets | To keep the meeting space clean
Refreshments | Lunch and cool drinks or water (Be attentive to the dietary requirements of the representatives of different religions).
Money | Transport money in correct cash amounts in envelopes

*Note: It is helpful to carry all of this in a suitcase dedicated to the purpose.*

### 3.2.8. Set up the workshop environment

There are quite a number of practical things for the exercises that can be done prior to the workshop to save time on the day. The PIRHANA workshops are intensive with many things happening at once. The better prepared the team are before-hand, the more they are able to engage with the participants.

It is important to check the venue the day before the workshop for the following:
- Table and chair arrangement
- Electricity and power points
- Wall space for newsprint
- Space for a registration table
- Section for a facilitators’ workspace

Team members will need to **photocopy** the following forms to create a participant pack:
- consent forms
- registration forms
- ARHAP information sheets

For the **Health Providers** you will need to add:
- spidergram forms
- Map and accompanying map verification forms

*Health Seekers:*
Prior to workshops team members will need to prepare:
- Community map pages (stick 4 newsprint pages)
- religion/health index (stick 2 newsprint pages)
- Bean sheets (stick 4 newsprint pages together and draw basic grid - see exercise below)
- Local action (2 newsprints stick together)
- Posters detailing ARHAP and PIRHANA objectives

*Health Providers*
Prior to workshops team members will need to prepare:
- timeline (stick 6 newsprint pages and draw lines see exercise below)
• religion/health index (stick 2 newsprint pages)
• Map and accompanying map verification form
• Networking exercise (stick 4 newsprint into a square. Draw circles for at least number of participants see exercise below)
• Local action (2 newsprints stick together)
• Posters detailing ARHAP and PIRHANA objectives

Time management is important on the day of the workshop. So, the facilitator and his/her team must be at the venue at least two hours before the workshop to set up the venue, prepare the welcome and registration desk, and to meet people as they arrive.

3.3. Community orientation

Prior to the actual workshop, the facilitators of the provider-level PIRHANA need a basic orientation to the context. This involves two elements: (i) access to baseline data, and (ii) a community orientation walk.

3.3.1. Important data

Each context – whether that of health providers or health seekers – has a socio-economic and cultural context that impacts upon religion and health. It is vital to have a working knowledge of these elements in the context in which the PIRHANA exercises will be undertaken. This will enable the team to engage better with the workshop participants, probe the right questions, and pick up the under currents.

It will be important to have access to the following background information:

1. Orientation to a map of the community to provide an overview of size, boundaries, major physical features (rivers, mountains, transportation routes, neighbouring towns/villages)
2. Sketch of demographics: Estimated number of residents, age/race/gender, long-term residents or new/migratory
3. Level of development: Current socio-economic level, any recent changes/impacts on the community (e.g., new businesses, new technologies, pullout of major industries, crop failures)
4. Social history: Origins? Lifespan?

This information can be gained through WHO and UN reports, government and NGO reports, and studies undertaken by anthropologists, sociologists and similar scholarly researchers.

3.3.2. Community orientation walk (transect walk)

Aside from the 'book knowledge' noted above, it is vital to undertake an orientation walk (or drive) through the community accompanied by two or three guides who can engage with the facilitators in discussion. Depending on local conditions and time constraints this could take between 1 and 3 hours, and should take place the preceding day.

The walk should be led by a guide, someone who is rooted in the community, with understanding of community history, assets and dynamics and good translation skills
3.3.3. Community indicators

Whilst engaging in the orientation walk, these are items and behaviours that may provide a lens on community health and wholeness and on community ‘readiness’ or opportunities for engagement in health activities.

1. **Overall environment**
   - Setting (rural/urban, physical features)
   - Accessibility
   - Density (population & structural)
   - Air quality
   - Water availability and quality
   - Food availability and quality
   - Cleanliness
   - Safety
   - Vectors (mosquitoes/rats/etc)
   - Animals
   - Climate/temperature & protection
   - Soil quality/erosion/deforestation
   - Aesthetic beauty: music, art, pictures, sculptures, etc.
   - Welcoming environment

2. **Community infrastructure**
   - Water source(s) and systems
   - Electricity
   - Roads/streets/sidewalks/transportation system
   - Sewage disposal
   - Communications/satellite/antennas/internet access

3. **Community resources**
   - Businesses
     - Local market
     - Microenterprise
     - Major employers
   - Schools
   - Churches
   - Health/public health facilities/traditional healers

4. **Health indicators/behaviours**
   - Overall physical appearance of residents (weight, wounds/lesions, jaundice, injuries, mutilation, paralysis)
   - Representative mix of age groups/gender (e.g., healthy infants/breastfeeding)/roles of women
   - Play, humour
   - Activity level/community ‘energy’/resident interaction(s)
   - Welcoming behaviour/smiles!
   - Clothing/shoes/eyeglasses
   - Soliciting/begging, aggressive approaches, drinking/drug use, violence
   - Language

5. **Spiritual practices**
   - Prayer
   - Worship
   - Singing
   - Display of signs/symbols
   - Death/burial rituals

6. **Navigability**
   - ‘Fee’ for living in the community
   - Facilitators and barriers to health-seeking behaviour
3.4. Team for PIRHANA workshops

3.4.1. Research officer and preparatory work

As we have noted above, the most crucial member of the PIRHANA team does his or her work before the team arrives. This is the research officer who is tasked with the preparatory work, and for setting up the workshop. He or she then plays a crucial role on the team, usually taking on one of the leadership roles (see below).

3.4.2. Roles in the workshop itself

Once the workshop gets under way, the following roles are important:

1. Facilitator/s: to provide the main leadership for the workshop. This person needs to be familiar with fundamental ARHAP theory and frameworks, and trained to lead the process.

2. Translator: if necessary to translate throughout if the facilitator is not familiar with the language.

3. Registrar: to staff the registration table (hand out name tags, get demographics forms filled in, liaise with host institution, be the bouncer! etc), and then to assist with various administrative and financial tasks.

4. Data capturer: to focus on collecting and storing the data (camera, dictaphone, recording, collection and filing of all data, with special attention to the interpretive data).

5. Assistant/s: One or two people to help with making matrices, time lines, distributing material, collecting & arranging index cards and ‘post-it’ cards.

6. Time keeper: This task may be given to one of the assistants. It is an important role for there are a number of exercises that need to fit into the day

7. Writing assistant: In some communities there may be illiterate people. It is helpful to have someone familiar with the local language who is free to unobtrusively assist with writing if necessary.

3.4.3. Communication

It is crucial that the team be able to communicate openly and freely with one another, and that the facilitator be open to on-the-spot monitoring and evaluation by members of the team so that problems can be immediately dealt with. The mix of group work and plenary exercises means that there are times when it is relatively easy for the team to converse, and other times when it is best to let the process unfold.
3.5. Running a PIRHANA workshop

Please note that this section provides an overview of the workshop. Chapter 4 details the specific exercises that are undertaken in detail.

3.5.1. Registration information

We need to keep a record of who participated in the workshop for two different reasons. The first is to enable us to get a quick overview of who is present, and to facilitate payment of travel expenses (where appropriate). The second is to build the profile of the study population.

Previously we have used the same list for both reasons. However, we have become aware that in some contexts issues of age, education as well marital status can be very sensitive. Because it is important to show sensitivity to issues related to customs and culture, it is suggested that two separate forms be used.

1. An attendance record that is an open list that includes only the person’s name, the community they reside in, and receipt of payment.

2. A participant registration sheet that is filled in individually and that seeks the following information:

- Name
- Age
- Sex
- Home language
- Occupation
- Religious affiliation
- Education level
- Years resident in community
- Marital status

Depending on the particular focus of the PIRHANA process, these participant registration sheets can also be used to gather organisational data – for example, if GIS mapping is occurring around the PIRHANA workshops and further information is required about the health facilities which the participants represent. However, if additional data is requested, it should not be so time-consuming that filling out the form slows down the workshop process. (There are various ways GIS mapping can be linked in with the PIRHANA workshops, see below and separate handbook on PIRHANA-PGIS).

3.5.2. Consent

The ethics process as described in section 1.5. needs to be followed carefully, and the consent forms need to be signed and stored. It is important for people to give consent for their participation in the workshop. The consent form must be read clearly in a language that a person(s) can understand.

Participants need to know that they have a right to withdraw from the process. At the same time, those that refuse to give consent have to know that they cannot be part of the workshop. In such circumstances it is best to invite the participant to step outside for a discussion with one of the team rather than to engage in a public debate which can delay the workshop start.
3.5.3. Questions of power

The health-seeker PIRHANA is used with local community members. Whilst it is not always possible to be exclusive in this process, attention is drawn to issues of power and domination when community leaders such as pastors, teachers, and elected officials are present in gatherings with community members. If this cannot be avoided then special care needs to be taken to be sensitive to possible domination or deference.

By the same token, even at the health-provider level, in certain contexts there can be a power differential between men and women, between elders and youth, or between the visiting research team and participants – and sensitivity will need to be exercised, such as providing different small groups (based for example on gender) to encourage open discussion and participation. A special concern that arises in these workshops is the marginalization of smaller religious groupings, and facilitators must always been attentive to this.

3.5.4. Facilitation matters

Given all the elements that we have noted above, to be the facilitator of a PIRHANA workshop requires training. During this process, a number of facilitation issues will be identified, as they have also been identified above. Here we raise up some key matters that need to be kept in mind at all times.

(a) Time management.
The whole workshop is designed to hang together, moving from one exercise to the next, and if too much time is spent on one exercise then something will have to be left out. Also, it is possible that spending too much time on one exercise arises from the agendas of certain dominant individuals within the group, and this needs to be carefully moderated. At the same time, the facilitator is not a slave to time and needs to be flexible enough for significant issues to emerge.

(b) Language and literacy
Community members often do not speak and write in the language of the research team. The team needs to be prepared to assist in these circumstances, and never to make a connection between a lack of literacy and a lack of wisdom.

(c) Use of examples
There are times when an instruction for an exercise can be met with blank stares. Sometimes an example is requested to get the process moving, and so it is worth thinking through a range of these prior to the workshop. However, bear in mind that examples provided by facilitators can skew the findings from the group, so be extremely careful that the group doesn't simply give back to the facilitators what they have been given. The exercises have mainly been designed to counteract this, providing a second round of responses (see below) – but is remains important for facilitators to be aware of their responsibilities in leading the discussion in this way.

(d) Administrative assistant.
Facilitating the workshop is exciting and engaging business, and it may be that everyone on the team wants to get involved. However, it is very important to have an assistant dedicated to deal with administration, finance and other practical matters (lunch etc).

(e) Inter-religious conflict
It is possible that conflict can arise from having representatives of different religious communities together in a workshop to reflect on the role of religion in an aspect of public life. This could be in the form of jealousy, self-righteousness, fundamentalist exclusiveness, and prejudiced opinions. Facilitators will need to respect faith claims, but seek to guide such discussions towards the contextual concerns of health and wellbeing, and the common commitment to use all the available assets to strengthen community life.
3.6. The logic of the health seeker PIRHANA workshop

The local-level PIRHANA enfolds as follows. (The exercises are described in detail in the next chapter)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00</td>
<td>Participants arrive and fill in the registration form&lt;br&gt;Refreshments provided</td>
</tr>
<tr>
<td>9.30</td>
<td>Welcome and Introduction&lt;br&gt;Signing of consent form (see section 5, Chapter 1)</td>
</tr>
<tr>
<td>9.45</td>
<td>1. Community map</td>
</tr>
<tr>
<td>10.15</td>
<td>Report back on community map</td>
</tr>
<tr>
<td>10.45</td>
<td>2. Health and sickness index</td>
</tr>
<tr>
<td>11.45</td>
<td>3. Religious Entity/health ranking</td>
</tr>
<tr>
<td>12.30</td>
<td>Report back and analysis</td>
</tr>
<tr>
<td>13.00</td>
<td>Lunch break</td>
</tr>
<tr>
<td>13.45</td>
<td>4. Religion/Health index</td>
</tr>
<tr>
<td>14.15</td>
<td>5. Religion/health ranking</td>
</tr>
<tr>
<td>14.45</td>
<td>Report back and analysis</td>
</tr>
<tr>
<td>15.15</td>
<td>6. Characteristics of Good Religious Entities</td>
</tr>
<tr>
<td>16.00</td>
<td>7. Local Action</td>
</tr>
<tr>
<td>16.25</td>
<td>Closure and thanks</td>
</tr>
</tbody>
</table>

Within 24 hours - 8. Team debriefing

Chapter four is specifically focused on the exercises that make up the health-seeker workshop. They are put together there for easy reference in the workshop environment.

The exercises of the PIRHANA have a logical flow to them. It is important that facilitators understand this and see the connection between the exercises, and why they follow one another in the way that they do. They are not just a set of exercises, but a particular research process that has an integrity that must be respected.

3.6.1. Step 1: Contextual considerations

The exercises begin with a deliberate focus on context. Prior to the workshops the research team is led by key informants on a community orientation walk (sometimes called a transect walk) through a section of the community. The workshops then begin with participants drawing community maps (exercise 1) and
identifying the key religious and social entities and facilities in their community. In the light of insights gained through the transect walk and other preparatory work, the research team are able to dialogue with community members about the context. Information on the maps is used in exercise 3.

### 3.6.2. Step 2: Health and wellbeing within the community context

Having engaged in conversation about context, participants are then asked in exercise 2 to identify the key factors that both (i) contribute to and (ii) undermine health and wellbeing in the community. These two sets of factors are then integrated in a participatory discussion to create a contextual group-identified health and wellbeing index. This gives us a picture of what the key health issues in the community are perceived to be.

### 3.6.3. Step 3: The contribution of community facilities to community health and wellbeing

Exercise 3 then combines some of the key social facilities (including religious entities) identified in the maps of Exercise 1 with key factors contributing to health and well-being from Exercise 2 to create a facility/health ranking matrix. This enables participants to rank the relative contribution of community facilities to the group-identified factors contributing to health and wellbeing. This process enables us to get a picture of the relative contribution of religious entities to health and wellbeing.

### 3.6.4. Step 4: The contribution of religion to health and wellbeing

Exercise 4 moves the focus specifically to the perceived contribution of religion to health and wellbeing, and through a participatory process a religion and health index is created. These broad factors are then synthesized and prioritised in a participatory discussion into a group-identified set of key religious factors.

### 3.6.5. Step 5: The relative contribution of religious entities to health and wellbeing

This process closely follows that used to create the facility/health ranking matrix in exercise 3. It draws together the religious entities that are identified in the transect walk and the community maps (exercise 2) with the synthesized key religious factors of exercise 4, and enables participants to rank the relative contribution of religious entities to the group-identified religious factors. In this way exercise 5 leads to the creation of a health/religious entity ranking matrix.

### 3.6.6. Step 6: Identification of characteristics of REs that are successful RHAs

The previous exercises are undertaken with a great deal of intensive discussion in small groups and in plenary, and participants are strongly immersed in thinking about the contribution of religion and religious entities to health and wellbeing and to the language of Religious Health Assets. In exercise 6 they are asked to identify what they consider to be the most important characteristics of a Religious Entity that is a successful RHA, thus providing a set of group-identified characteristics of exemplar RHAs. They are then invited to identify the best examples in their community.

### 3.6.7. Step 7: Local action

As a respectful and appreciative research tool, PIRHANA does not end with the research teams’ extracting the data for their own purposes. Throughout the workshop all the information that is being accessed by the research team is at the same time being accessed by the participants. For this reason the workshop ends with an intentional time for participants to talk amongst themselves about what they would like to do with the information they had generated and to make any appropriate local commitment to take forward the process (exercise 7).
3.7. The logic of the health provider PIRHANA workshop

The health provider level PIRHANA enfolds as follows (the exercises are described in detail in the next chapter)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30</td>
<td>Participants arrive, registration</td>
</tr>
<tr>
<td>9.00</td>
<td>Welcome and introduction to ARHAP</td>
</tr>
<tr>
<td></td>
<td>Introduction of participants</td>
</tr>
<tr>
<td></td>
<td>Introduction to PIRHANA</td>
</tr>
<tr>
<td></td>
<td>Explanation and signing of consent forms</td>
</tr>
<tr>
<td>9.30</td>
<td>1. <em>Time line and time trends</em></td>
</tr>
<tr>
<td>10.45</td>
<td>2. <em>Religious/health index</em></td>
</tr>
<tr>
<td>11.45</td>
<td>3. <em>Verification of maps</em></td>
</tr>
<tr>
<td>12.45</td>
<td>Lunch</td>
</tr>
<tr>
<td>13.30</td>
<td>4. <em>Spider web</em></td>
</tr>
<tr>
<td>15.00</td>
<td>5. <em>Characteristics of Good Practice</em></td>
</tr>
<tr>
<td>16.00</td>
<td>6. <em>Local Action</em></td>
</tr>
<tr>
<td>16.25</td>
<td>Closure and thanks</td>
</tr>
<tr>
<td></td>
<td>Within 24 hours - Team debriefing</td>
</tr>
</tbody>
</table>

Chapter five is specifically focused on the exercises that make up the health-provider workshop. They are put together there for easy reference in the workshop environment.

The exercises of PIRHANA have a logical flow to them. It is important that facilitators understand this and see the connection between the exercises, and why they follow one another in the way that they do. They are not just a set of exercises, but a particular research process that has an integrity that must be respected.

3.7.1. Step 1: Considerations of context: ‘space’

The health provider-level workshops begin with a community orientation walk or drive around key areas in the region. Then, in the workshop, participants undertake a series of exercises that raise contextual matters to the fore. Of particular importance is the *timeline*, in which participants locate events to do with religion and health into a wider socio-political context and the *mapping exercise* in which participants use maps of the region and the town and identify the presence of health-related entities (both general and religious).
3.7.2. Step 2: Considerations of context: ‘time’

Assets, networks and agency exist in time and are therefore always in flux and always responding to changing circumstances. What we map today may not have been there a year ago, and may well not be there in a year’s time, and thus the timeline exercise gives participants and the research team an opportunity to reflect on the causes and effects of certain events and their wider relationships. This exercise also enables participants to reflect on the wider constraints in which the struggle for health and wellbeing takes place.

3.7.3. Step 3: The contribution of religion to health and wellbeing

The next exercise sees the focus moving to the perceived contribution of religion to health and wellbeing, and through a participatory process a religion and health index is created. These broad factors are then synthesized and prioritized through a participatory discussion into a group-identified set of key religious factors. In this process participants are introduced to the concept of Religious Health Assets.

3.7.4. Step 4: RHAs and their relationships

In the process of the timeline and mapping exercises, a range of significant religious entities, and other health facilities are identified. These are used in a spidergram exercise in which participants map the relationships among the entities, enabling us and them to identify the nature and scope of these relationships.

3.7.5. Step 5: Characteristics of good practice

With the data from and discussions around the previous exercises to do with the timeline, mapping exercise, spidergram, religion and health index, and religious health assets fresh in their minds, participants are now asked to identify the characteristics of good practice in their community, and to identify any particular exemplars in the community.

3.7.6. Step 6: Local action

As a respectful and appreciative research tool, PIRHANA does not end with the research teams’ walking away with the data for their own purposes. Throughout the workshop all the information that is being accessed by the research team is at the same time being accessed by the participants. For this reason the workshop ends with an intentional time for participants to talk amongst themselves about what they would like to do with the information that they have generated and to plan any appropriate local action to take forward the process.

3.8. Valuing the workshop

At the start of this chapter (3.1.) we noted that the PIRHANA is a three-fold process. Thus far we have drawn attention to preparing for and running a health provider workshop, and we now turn our attention to what happens after the workshop – what we call ‘valuing’ what has happened.
3.8.1. Research record

In the midst of the excitement of community engagement and empowerment it is sometimes hard to remember that PIRHANA is a research process.

It is very important to keep all the data that emerges from the process, including:

- Consent forms
- Participant register
- Hard copies and photographs of all maps, indices and matrixes
- Record of actual data in answering questions
- Tape recordings of discussions – which must be transcribed
- Insights from the debriefing sessions

This is why it is crucial to appoint a data capturer whose major task is to see to the safekeeping of this data (see 3.4.). The data that emerges from the workshops needs to be properly recorded and stored in a safe and secure place.

As soon as the workshops are over, care must be taken to get this data captured on computer and integrated into the research process. This contributes the first and second elements of a workshop report (see below).

3.8.2. Debriefing – following the workshop

Other than the hard data that emerges from the workshops (see 3.8), it is vital to undertake a debriefing exercise after a PIRHANA workshop so that the perceptions of the facilitators are gathered. These contribute to the third element of the research report.

Debriefing is of value to strengthen team relationships and ‘assets’, identify key research findings, deepen shared understandings, and continue to refine the participatory mapping processes. It is suggested that the process follows that of a workshop exercise, which will be more familiar to facilitators once they have worked through Chapter 4.

The Senior Investigator needs to take responsibility for this, and must lead the process or appoint someone to lead it. It is not a good idea to use the Research Officer, as he or she will be too close to the process, and probably exhausted!

**Equipment:**
- Comfortable setting, chairs in a circle
- Board or other surface for posting notes
- Packet of Post-it Notes for each team member
- Marker Pens for each team member

**Questions to Pose to the Group; dialogue should be open and accessible to all. For questions participants will record their answers on post-it notes for sharing and discussion with the group.**

1. How/What are you feeling today, at the completion of the workshop?

2. What new questions/areas of research emerged during this workshop? Were there other significant surprises/unanticipated discoveries? Should/how should these be pursued?

3. What did we learn about Religious Health Assets in this workshop?
4. What do you believe are the most important things that the participants got from the workshop? Or...How did the workshop benefit the participants?

5. What particular approaches worked well and/or did not work well in this workshop? (Probe for specifics.) Can these approaches be corrected or further refined?

The key elements that emerge from this process need to be recorded for use in the workshop report.

3.8.3. Follow up with participants

We have repeatedly noted that the PIRHANA research approach seeks to be non-extractive. One of the ways of ensuring this is to have an intentional policy of ‘follow-up’ with the participants. This needs to be talked through with them in the final exercise on ‘local action’.

Some of the options are:
- Providing a directory of organisations (from the registration forms)
- Providing a copy of the research data (see 3.9. below)
- Providing a full research report (see 3.9. below)
- Providing the GIS maps and information (if the further GIS component was added)
- If the workshops is part of a wider research project, to provide access to the findings of this wider project.

3.8.4. Follow up with ARHAP

This is Version 5 of PIRHANA, and it has gotten better through the constant feedback of practitioners who have provided an evaluation of some of the processes and exercises.

It is important that ARHAP get this kind of feedback from people who use the tool. The debriefing session (3.8.2. above), includes a section on tool improvement and assessment, and this information should be forwarded to ARHAP.

3.9. Workshop report

A key aspect of valuing the PIRHANA workshop is to produce the workshop report. This needs to be done as soon after the process as possible for each specific workshop without exception. It integrates the information that emerges from the research record (3.9.1.) and the debriefing (3.9.2.)

The report has three sections to it.

3.9.1. Research data

This needs to capture in simple form the following seven elements from the seven exercises.

1. *The maps, or photographs of the community maps* - Apart from the maps themselves, this needs to be accompanied by a list of the key social and religious entities that are identified on the maps.

2. *The health and sickness index* - This should be in the form of two tables of elements with the ‘scores’ that they receive.
3. Religious entity/health ranking - This is in the form of a matrix with the key social entities that are chosen in exercise 1 and elements from exercise 2 ranked against each other with a score out of 5.

4. Religious/health index - This should be a table of elements with the 'scores' they receive.

5. Religion/health ranking - This is in the form of a matrix with the key religious entities that are chosen in exercise 1 and elements from exercise 4 ranked against each other with a score out of 5

6. Characteristics of good religious entities - This should be a table of elements with the 'scores' they receive. Secondly it should include a list of possible exemplars in the community, with contact details.

7. Local Action - It is important to get a list of the actions that the group commitment to undertaken in the light of what has emerged in the workshop.

### 3.9.2. Discussion

Thus far we have captured the 'quantitative' data, but in the workshops a great deal of qualitative data also emerges in the discussions amongst the participants. This needs to be recorded through note-taking and/or through tape-recording and subsequent transcription. In this section of the report the comments that emerge from the participants need to be captured.

### 3.9.3. Observation

The third elements of the report comes from the team debriefing, as the facilitators and others record their observations of what happened, and why certain data emerged in the way that it did.

Of particular importance here is the integration of the observations from the community orientation walk. These need to be captured in the report, and reflected against what has happened, as they provide information about the context in which the workshop took place.

### 3.10. Data synthesis and analysis

The data that is captured in the workshop report (3.9.) is both quantitative and qualitative, and it rests in a wider social, religious and health context. Following a series of workshops this data needs to be synthesized and analysed.

This theoretical and scholarly work can move in a wide number of directions in terms of the five aims of PIRHANA (see 1.2.4.), and it would be impossible to lay this out in this manual. However it is important to note what the data does and does not do. Returning to the research process (1.4. and especially 1.4.3.) will help to understand this.
3.10.1. What the data does not allow for

Quite a bit of quantitative data will emerge in the workshop report, and this may seduce the researcher into thinking that cold objective truth has been established. This is not the case for three important reasons.

1. The study population, identified through stratified purposive sampling making use of a snowball process, is not the kind of sample that will provide evidence that is generalizable to a wider population.

2. The workshops are undertaken with knowledgeable people, often understood as key informants. Nevertheless, the questions in the workshops are exploring their perceptions of the truth, not the truth itself.

3. The participants will know that the workshop is being run by people who are interested in religion. There may be a tendency to give more weight to ‘religious’ factors in the discussion.

Another important issue to bear in mind is that the inductive approach to the research means that there will be an unevenness in the elements that appear in the data across study sites, and one must be careful of trying to force comparisons.

Thus it is important that in the analysis of the data the researchers are realistic about what they are dealing with, and be careful of claiming to have ‘proved’ anything.

3.10.2. What the data does allow for

The data that emerges from a PIRHANA workshop is a rich, qualitative repository of community knowledge about the links between religion and health in a given context. This data is expressed in quantitative terms which does allow for simpler analysis and comparison.

This data is significant for 3 reasons:

1. We recognise that understandings of health and religion is governed by the healthworlds of the participants, and that these healthworlds drive the ways people live and engage. The PIRHANA workshops are designed to provide an intensive picture of the elements that make up these healthworlds, and this is extremely valuable knowledge.

2. If the preparatory work has been done well, and the participant register will attest to this, then the workshop should comprise of key informants who can speak with some authority about religion and health in the community. These may be perceptions, but they are very important perceptions.

3. As noted in 1.4.3., the data that emerges in the workshops is produced in an open, transparent, and peer-reviewed manner. What is shared is immediately open to public scrutiny and correction. This means that it is likely that what is being shared is in fact the common knowledge that resides in the community – and that the research team can be pretty certain about its authenticity.

In summary then, the data can be understood to be:

- The perceptions of key informants
- Authentic community knowledge
- Valuable insights into what drives the agency of health seekers and providers
- Quantitative expressions of these factors that facilitates analysis and comparison.
3.10.3. Interface with other available data and knowledge

PIRHANA is not intended to be a stand-alone tool for the analysis of religion health assets. Many other tools are necessary to gain a fuller picture. This includes ethnographic studies, case studies, focus groups, questionnaires, interviews with key informants, GIS mapping, surveys, and the like.

Each of the PIRHANA exercises provides a window on a certain issue, but the data that emerges needs to be analysed and interpreted within a wider framework of theory and research.

3.10.4. Identifying and analysing the research findings

The data that emerges in the workshops needs to be captured and reflected upon, but the overall research findings are drawn from an engagement with a series of workshop reports, and with a dialogue with the wider theoretical and research framework identified in 3.10.3 above.

It is difficult to lay this out in a manual of this nature, as it relies upon the insights and perceptions of the team entrusted with writing up this kind of wider report. For more ideas on this, see the ARHAP report, ‘Appreciating Assets’ (2006).
# CHAPTER 4:
## THE HEALTH SEEKER WORKSHOP EXERCISES

![](image)

### 4.1. Community mapping

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th><strong>Operational information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>It serves as an ice-breaker to get people working together;</td>
</tr>
<tr>
<td>2.</td>
<td>It locates the rest of the workshop in the real-life context of the community;</td>
</tr>
<tr>
<td>3.</td>
<td>It provides the facilitator with insights into community life that can be used in the next exercises; and</td>
</tr>
<tr>
<td>4.</td>
<td>It identifies perceptions of health and key religious ‘assets’ that already exist in the community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Articulation</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Exercise 3. The key social and religious entities are used in the matrix</td>
<td></td>
</tr>
<tr>
<td>● Exercise 5. The key religious entities are used in the matrix</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Data</strong></th>
<th>Keep the maps, or good digital photographs of the maps.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Equipment</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● A range of marker pens in different colours for each group</td>
<td></td>
</tr>
<tr>
<td>● 3 to 4 sheets of newsprint for each group</td>
<td></td>
</tr>
<tr>
<td>● Masking tape or prestick to attach the maps to the walls.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Time</strong></th>
<th>60 mins. (30 mins on map, 30 mins report back)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Tasks</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Group work – drawing maps</td>
</tr>
<tr>
<td>2.</td>
<td>Plenary – discussing the maps</td>
</tr>
</tbody>
</table>
4.1.2. Task 1: Group work

The participants are divided into three or four small groups with sheets of newsprint and marker pens. It is helpful to divide women and men into separate groups, and possibly elders and youth. The facilitator says:

 Please draw a map of the local community area, and locate on it all the key public entities – such as schools, police, churches, markets, clinics, etc. - in the community on the map.

Note: It is not expected that this is a perfectly accurate map, and groups will need to be encouraged to work with broad strokes rather than with attention to minute detail.

The team member responsible for gathering data should make a note of which maps emerge from which groups. It is helpful to draw a rough diagram of the location of each group in the room, as well as noting the facilitator’s group divisions i.e. the makeup (male-female ratio or geographic location).

4.1.3. Task 2: Plenary engagement

The larger group then gathers around each map, and the small groups have a short report-back on their map. The facilitator raises questions, probes and compares the maps. Of crucial importance is to identify and create two lists on newsprint:

1. the social structures that exist in the community such as schools, markets, police stations, hospitals, cemeteries, rivers, roads, courts, clinics, shops, bars, etc.

2. the different kinds of religious organisations, entities, formations, and structures that are in the community such as: religious buildings, church clinics, prayer meetings, faith healers, traditional churches, pentecostal ministries, mosques, temples, care groups, religious schools, faith-based organisations, health facilities, hospices, orphanages, etc.
4.2. Health and sickness index

4.2.1. Operational information

| Objectives | 1. A participant driven list of factors that impact upon human health that is both important in its own right, and important for the next exercise.  
2. A reflective discussion on the significance of these factors for the participants. |
| Articulation | Exercise 3: The top factors that are identified are used in the matrix |
| Data | 1. The wide ranging answers for the first and third tasks  
2. The index that is created in the second and fourth tasks.  
3. The synthesized list of the top factors that is created |
| Equipment | • A marker pen for each participant  
• At least 8 large index cards for each participant  
• 3 sheets of newsprint  
• Tape recorder |
| Time | 60 minutes |
| Tasks | 1. Brainstorm 1  
2. Creating the first index  
3. Brainstorm 2  
4. Creating the second index  
5. Recorded discussion  
6. Integrating the factors |

4.2.2. Task 1: Brainstorm 1

Participants are given two index cards and a marker pen. They are asked to write down the answer to the question:

≡ What do you consider to be the two key factors that cause well-being in this community. Write one or two words for each factor on each card.¹

Participants are told that this is in the form of a brainstorm, and that there will be a chance to think more about this, so they need not be too anxious to get the perfect answer.

If the group seems stuck, examples may be provided. These should draw attention to both tangible and intangible and factors:

Clinics  
Hope  
Prayer

The cards are collected and laid out randomly on the floor. There is no problem if participants choose words suggested by the facilitators. Duplicates are noted but not laid down.

¹ Note: the term well-being is used rather than ‘good health’, as it is more likely to be closer to the meaning of the word that is used when translated into an African language (see Bophelo in chapter 3)
4.2.3. Task 2: Creating the first index

The first task is repeated, but participants are now asked to choose what they consider to be the two most important factors from the cards on the floor.

Remind them of the question:

\[ \text{What do you consider to be the two key factors that cause well-being in this community. Write one or two words for each factor on each card.} \]

These cards are collected and then laid out on the floor. When a card repeats what a previous card has said, it is laid down above its namesake.

Clearly the facilitator needs to group together words that express the same factor even if they are different words (eg. nutrition = good food = healthy food = food; knowledge = education = understanding; etc.)

In this way a ‘bar graph’ of the key factors that the participants believe cause good health is created, and the participants can see what they themselves believe to be the key factors. The cards are left on the floor for step 2.

4.2.4. Task 3: Brainstorm 2

The first exercise is repeated, but the question is changed. Now participants are asked to write down the answer to the question:

\[ \text{What do you consider to be the two key factors that work against well-being in this community. Write one or two words for each factor on each card.} \]

If the group is stuck examples. These should draw attention to both tangible and intangible and factors:

- Alcohol
- Poverty
- despair

The cards are collected and laid out randomly on the floor. There is no problem if participants choose words suggested by the facilitators. Duplicates are noted but not laid down.

4.2.4. Task 4: Creating the second index

The previous task is repeated, but participants are now asked to choose what they consider to be the two most important factors from the cards on the floor.

Remind them of the question:

\[ \text{What do you consider to be the two key factors that work against well-being in this community. Write one or two words for each factor on each card.} \]

These cards are collected and then laid out on the floor alongside the earlier set. When a card repeats what a previous card has said, it is laid down above its namesake. Again the facilitator will need to group ‘ideas’ rather than exact words together.

\footnote{Note: the term well-being is used rather than ‘good health’, as it is more likely to be closer to the meaning of the word that is used when translated into an African language (see Bophelo in chapter 3)}
In this way a ‘bar graph’ of the key factors that the participants believe cause sickness is created, and the participants can see what they themselves believe to be the key factors.

### 4.2.5. Task 5: Recorded discussion

Through probing questions participants are engaged in reflective discussion on the reasons that certain factors are more significant than others. This should be recorded by tape recorder for later transcription as it is likely to contain key insights.

### 4.2.6. Task 6: Integrating the factors

*This task is aimed at producing the factors for consideration in exercise 3.*

Flowing directly out of the discussion, the facilitator – in constant dialogue with the participants - draws together the key factors that contribute to health – either positively or negatively. This requires some lateral thinking as for example the following list may be generated (votes in brackets):

<table>
<thead>
<tr>
<th>Well-being</th>
<th>Against well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food (9)</td>
<td>Poverty (9)</td>
</tr>
<tr>
<td>Knowledge (6)</td>
<td>Ignorance (7)</td>
</tr>
<tr>
<td>Faith in God (5)</td>
<td>Pollution (6)</td>
</tr>
<tr>
<td>Good sanitation (5)</td>
<td>Bad nutrition (5)</td>
</tr>
<tr>
<td>Marital faithfulness (3)</td>
<td>Bad morals (3)</td>
</tr>
<tr>
<td>Water (2)</td>
<td>No employment (1)</td>
</tr>
<tr>
<td>Medicine (2)</td>
<td>HIV/AIDS (1)</td>
</tr>
</tbody>
</table>

Food is a clear factor for good health and bad nutrition a factor in sickness – but clearly they express the same idea, and so only one word is chosen. Likewise, ignorance and knowledge express the same idea. Depending on how people understand pollution, it may be the flip-side of good sanitation. Thus, after some discussion, the participants agree on a combined set of five or six key factors contribute to health in the community. In the above case would probably be:

- Nutrition
- Knowledge
- Faith in God
- Against Poverty
- Against Pollution

Note that ‘negative’ factors like poverty and pollution are expressed with the word ‘against’ in front of them.

These factors are now to be used in the next exercise.
4.3. Facility/health ranking

4.3.1. Operational information

| Objectives | 1. A picture of the relative contribution to health from each key public entity, and a discussion on reasons for this  
2. The relative contribution of religious entities to health in this community |
| Articulation | This exercise makes use of data that emerges from exercise 1 and exercise 2 |
| Data | 1. Photographs of the matrixes with the ‘bean count’  
2. The ‘master matrix’ |
| Equipment | • A set of prepared newsprint sheets with a matrix drawn on them. (This looks like an Excel spreadsheet) 11 columns and 7 rows.  
• At least 16 large post-it notes per group  
• A whole bag of beans, shared between the groups.  
• A prepared master matrix on newsprint that will be used for report back.  
• Tape recorder |
| Time | 45 mins for bean exercise, 30 mins for plenary discussion |
| Tasks | 1. Identifying the key public entities  
2. Bean matrix  
3. Composite matrix  
4. Recorded discussion |

4.3.2. Task 1: identifying the key public entities

The list of public entities (including religious entities) that emerged in the mapping exercise (4.1.3.) is brought back to the group, and the group identifies up to 10 key structures (may be less) that are important in the community. The facilitator ensures that there are a minimum of three ‘religious’ entities.

Discussion will allow nuances to emerge, such as different kinds of churches, or different kinds of clinics.

These 8 structures, and the 5 or 6 factors identified in exercise 2, are now written up on index cards and used in the next task.

(Note that there is a second exercise to look specifically at religious entities. This exercise is a broader look at all the structures that are present in the community.)

4.3.3. Task 2. Bean matrix

The group now returns to the smaller groups that were used in the mapping exercise.

Each group is given the blank newsprint matrix. The cards that have the 10 public entities on them are placed across the top, and the cards that have the 5 or 6 health factors are placed down the side. It should look something like this:
Each group is given a number of bowls of beans. Participants will then discuss and agree on each facility’s contribution to health in that community by placing a number of beans (high = 5, low = 0) alongside its contribution to that specific factor. As they proceed all the squares of the matrix will be dealt with.

### 4.3.4. Task 3. Composite matrix

The prepared master matrix is now put up, and a team member prepares to write down the scores from each group.

The facilitator invites each group in turn to shout out the scores for all the elements, and these are collated onto the master matrix. The groups need to be reminded that it is their scores that are being transferred to the master matrix.

It is worth keeping the scores of the different groups separate through use of different coloured marker pens.

### 4.3.5. Task 4: Recorded discussion

When all the scores are on the master matrix, the group returns to plenary. The facilitator does not need to go through all the scores, but just draw attention to the important agreements and disagreements in the answers.

The ensuing plenary discussion will explore these agreements and disagreements, and deal with the issue of ‘why’ the data emerges as it does.
# 4.4. Religion/Health index

## 4.4.1. Operational information

| Objectives | 1. A participant driven list of the key ways in which religion contributes to health that is both important in its own right, and important for the next exercise.  
| | 2. A reflective discussion on the significance of these factors for the participants. |
| Articulation | The factors that emerge here are used in exercise 5 |
| Data | 1. The wide ranging answers for the first task  
| | 2. The index that is created in the second task.  
| | 3. The synthesized list of the top factors that is created |
| Equipment | 1. 1 marker pen for each participant  
| | 2. At least 4 cards per participant  
| | 3. 3 sheets of newsprint  
| | 4. Tape recorder |
| Time | 30 mins |
| Tasks | 1. Brainstorm  
| | 2. Creation of the index  
| | 3. Recorded discussion |

## 4.4.2. Task 1: Brainstorm

Returning to plenary, participants are given two index cards and a marker pen. They are asked to write down the answer to the question:

> If the Ministry of Health asked you to identify the two most important ways that religion (including religious people, groups or organisations) contributes to health in your community – what would you say? Write these down on the two cards.

Participants are told that this is in the form of a brainstorm, and that there will be a chance to think more about this, so they need not be too anxious to get the perfect answer.

If the group seems stuck, examples may be provided. These should draw attention to both tangible and intangible and factors:

- Clinics
- Hope
- Prayer

The cards are collected and laid out randomly on the floor. There is no problem if participants choose words suggested by the facilitators. Duplicates are noted but not laid down.
4.4.3. Task 2: Creation of the index

The first task is repeated, but participants are now asked to choose what they consider to be the two most important factors from the cards on the floor.

Remind them of the question:

“If the Ministry of Health asked you to identify the two most important ways that religion (including religious people, groups or organisations) contributes to health in your community – what would you say? Write these down on the two cards.

These cards are collected and then laid out on the floor. When a card repeats what a previous card has said, it is laid down above its namesake. The facilitator will need to group ‘ideas’ rather than exact words together. In this way a ‘bar graph’ of the key ways in which religion contributes to health is created, and the participants can see what they themselves believe to be the key factors. Some factors might be:

- Hope
- Compassion
- Love
- Clinics
- Education
- Caring
- Training
- Prayers
- Morality
- Material support

4.4.4. Task 3: Recorded discussion

The facilitator engages with the participants on what is meant by the various factors. The data is probed to gain a deeper understanding of what participants mean.

The top 5 or 6 elements are then selected for use in the next exercise.

Attention must be given to ensure that these elements are sufficiently different to one another. The facilitator is reminded of the framework that emerged from previous ARHAP work:

- Curative Care
- Spiritual Encouragement
- Knowledge giving
- Curative interventions
- Material support
- Moral formation
- Relationship building
- Preventative actions

This should not prescribe the factors, but help to ensure that as comprehensive a list as possible does emerge.
4.5. Religion/health ranking

### 4.5.1. Operational information

| Objectives | 1. A picture of the way in which religion and religious entities contribute to health in the community  
2. A ranking of the relative strength of Religious Health Assets. |
| Articulation | The exercise draws from exercise 1 (mapping), and exercise 4. |
| Data | 1. Photographs of the matrixes with the ‘bean count’.  
2. The ‘master matrix’. |
| Equipment | • A set of prepared newsprint sheets with a matrix drawn on them. (This looks like an Excel spreadsheet) 11 columns and 7 rows.  
• At least 16 large post-it notes per group  
• A whole bag of beans, shared between the groups.  
• A prepared master matrix on newsprint that will be used for report back.  
• Tape recorder |
| Time | 30 mins for group work, 30 mins for plenary discussion |
| Tasks | 1. Identifying the key religious entities  
2. Bean matrix  
3. Composite matrix  
4. Recorded discussion  
5. Special focus questions |

### 4.5.2. Task 1: identifying the key religious entities

The list of religious entities that emerged in the mapping exercise (4.1.3.) is brought back to the group, and the group identifies up to 8 key entities that are important in the community.

Discussion will allow nuances to emerge, such as different kinds of churches, or different kinds of clinics, or different kinds of traditional healers.

These 8 entities, and the 5 or 6 factors identified in exercise 4, are now written up on index cards and used in the next task.

### 4.5.3. Task 2. Bean matrix

The group now returns to the smaller groups that were used in the mapping exercise.

Each group is given the blank newsprint matrix. The cards that have the 10 religious entities on them are placed across the top, and the cards that have the 5 or 6 religious factors are placed down the side. It should look something like this:
Participants will then discuss and agree on each religious entity’s contribution to health in that community by placing a number of beans (high = 5, low = 0) alongside its contribution to that specific factor. As they proceed all the squares of the matrix will be dealt with.

4.5.4. Task 3. Composite matrix

The prepared master matrix is now put up, and a team member prepares to write down the scores from each group.

The facilitator invites each group in turn to shout out the scores for all the element, and these are collated onto the master matrix. The groups need to be reminded that it is their scores that are being transferred to the master matrix.

It is worth keeping the scores of the different groups separate through use of different coloured marker pens.

4.5.5. Task 4: Recorded discussion

When all the scores are on the master matrix, the group returns to plenary. The facilitator does not need to go through all the scores, but just draw attention to the important agreements and disagreements in the answers.

The ensuing plenary discussion will explore these agreements and disagreements, and deal with the issue of ‘why’ the data emerges as it does.

If it seems appropriate, the facilitator poses the following question:

\[\begin{align*}
&= \text{Who was missing from this workshop? Who else should have been here?}\” \\
&= \text{Would they have told us different things? If so what?\”}
\end{align*}\]

4.5.6. Special focus

If the PIRHANA workshop is aimed at a special issue, this would be an appropriate time to introduce it into the workshop – if it has not already emerged. Here the facilitator would ask something about this, and illicit information about the way in which religion and religious entities might contribute to it.
4.6. Characteristics of good religious entities

**4.6.1. Operational information**

| **Objectives** | 1. To gain a perspective on what health seekers value in religious entities that provide health and wellbeing  
2. To develop a set of criteria for strong Religious Health Assets  
3. To identify key exemplar RHAs in the community |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Articulation</strong></td>
<td>This draws on the previous exercise</td>
</tr>
</tbody>
</table>
| **Data** | 1. The index of characteristics  
2. The list of exemplars and any further information that can be gained about them |
| **Equipment** | At least two cards for each participant  
Newsprint and marker pens |
| **Time** | 45 mins |
| **Tasks** | 1. Key characteristics  
2. Identification of exemplars |

**4.6.2. Task 1. Key characteristics**

Participants are given two cards, and asked to answer the question:

\[ We've\ looked\ at\ a\ number\ of\ organisations\ today,\ some\ are\ doing\ better\ than\ others.\ What,\ for\ you,\ are\ the\ qualities\ of\ a\ good\ religious\ entity\ contributing\ to\ health? \]

These cards are collected and then laid out on the floor. When a card repeats what a previous card has said, it is laid down above its namesake. The facilitator will need to group ‘ideas’ rather than exact words together. In this way a ‘bar graph’ of the key characteristic of Religious Health Assets is created, and the participants can see what they themselves believe to be the key factors.

**4.6.3. Task 2: Identification of exemplars**

Participants are now asked to think about organisations that they know of, and to think of which ones have the characteristics just identified.

These are written up on newsprint and discussion ensues as to why they have been chosen. Any contact information is noted.
4.7. Local action

4.7.1. Operational information

| Objectives | 1. To ‘hand over the stick’ to local leadership  
2. To stimulate individual commitment to action |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Articulation</td>
<td>This exercise draws on the energy of the whole workshop</td>
</tr>
<tr>
<td>Data</td>
<td>The commitments that are written on newsprint.</td>
</tr>
<tr>
<td>Equipment</td>
<td>Newsprint and marker pens</td>
</tr>
<tr>
<td>Time</td>
<td>25 minutes, with 5 minutes for closure and vote of thanks</td>
</tr>
</tbody>
</table>
| Tasks | 1. Group reflection  
2. Conclusion |

4.7.2. Group reflection

At this point, a local leader is invited to lead the discussion.

In plenary the facilitator poses the following question:

\[ \text{What can you do to help the other religious organisations and entities in your community to make a better contribution to health?} \]

Discussion can continue for as long as is possible amongst the participants before the meeting comes to an end.

Key decisions for action are noted on newsprint.

Note: this is not a research question, but is asked so that participants can engage with their own research findings.

4.7.3. Conclusion

When the time has come to close the workshop, the facilitators propose a vote of thanks to all who have participated and contributed.
CHAPTER 5: THE HEALTH PROVIDER WORKSHOP EXERCISES

5.1. Time-line and time-trends

5.1.1. Operational information

| Objectives | 1. A deeper appreciation of the historical trends that have shaped the current health situation  
2. A deeper appreciation of the social constraints in which the struggle for health and wellbeing takes place  
3. An introduction to the ‘story’ of the organisations in the workshop, and thus a better appreciation of one another. |
| Articulation | • This exercise sets the scene for the whole workshop.  
• The organisations that are named, are used in the spidergram  
• The final exercise returns to the social constraints for action. |
| Data | The timeline must be kept, and photographs taken of it |
| Equipment | • 6 sheets of newsprint prepared as a timeline  
• 1 marker pen per participant  
• Up to 5 post-it notes per participant. |
| Time | 1 hour 15 mins |
| Tasks | 3. Preparation  
4. Time line  
5. Recorded discussion |
5.1.2. Task 1: preparation

Preparation: Before the meeting starts the newsprint is put up on the wall, and a time-line is drawn that covers the period from 1900 to the present, segmented by decades and by each year for the past twenty years. The line is divided into four ‘tracks’: General social and political history; Formation of organisations; other key religious and health events. A fourth track can be added if a specific issue is being dealt with. It would look like this:

![Time-line diagram]

It is worth keeping the earlier dates, even though the lines may be drawn closer together at this point.

5.1.3. Task 2: Time line

Each participant is given 4 post-it notes. They are asked to write the following on each piece of paper together with an appropriate date:

- One key significant social, political or economic event
- The name of the organisation they represent or belong to
- A key event to do with religion or health
- A key religious or health event related to the special issue (if appropriate)

Then in plenary each takes turns to come and to stick their information on the time-line. When they place their organisation on the line at the point it was established, they can introduce it and the contribution it makes to health in the region (and beyond).

Notes:
1. It is helpful to have two facilitators for this exercise
2. The background and contextual information noted in the first chapters of the manual is helpful here so that probing questions can emerge
3. It is important for the facilitator to maintain strict control over the time that each person takes as this exercise can easily become a promotional exercise for organisations
4. It is very important for someone exclusively gathering data for this exercise as it is intensive

Once all participants are finished, the facilitator invites those present to take more post-it notes and to add to the time line any other important information.

5.1.4. Task 3: Recorded discussion

The facilitator invites people to comment on historical trends, and probes the inter-relationship between various factors.
Attention is drawn to the social, political, religious and cultural constraints that have emerged in history and that still impact upon the struggle for health and wellbeing today.
5.2. Religion/Health index

5.2.1. Operational information

<table>
<thead>
<tr>
<th>Objectives</th>
<th>A participant driven list of the key ways in which religion contributes to health that is both important in its own right, and important for the next exercise. A reflective discussion on the significance of these factors for the participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Articulation</td>
<td>This exercise stimulates discussion about the characteristics of good practice, exercise 5</td>
</tr>
</tbody>
</table>
| Data | 4. The wide ranging answers for the first task  
5. The index that is created in the second task.  
6. The synthesized list of the top factors that is created |
| Equipment | • 1 marker pen for each participant  
• 5 post-it notes per participant  
• Tape recorder |
| Time | 60 minutes |
| Tasks | 1. Brainstorm  
2. Creation of the index  
3. Recorded discussion and input  
4. Special focus |

5.2.2. Task 1: Brainstorm

Participants are then given two post-it notes and asked the question:

\[ \text{If the Ministry of Health asked you to identify the two most important ways that religion (including religious people, groups or organisations) contributes to health in your community – what would you say? Write these down on the two notes.} \]

Participants are told that this is in the form of a brainstorm, and that there will be a chance to think more about this, so they need not be too anxious to get the perfect answer.

If the group seems stuck, examples may be provided. These should draw attention to both tangible and intangible and factors:

- Clinics
- Hope
- Prayer

The post-it notes are collected and stuck up randomly on the wall. There is no problem if participants choose words suggested by the facilitators. Duplicates are noted but not stuck up.
5.2.3. Task 2: Creation of the index

Stimulated by this list of factors, participants are now asked to reconsider the question and to choose the two most important factors that have already been identified. These are written down on the post-it notes, which are collected and stuck up on the wall.

When a note repeats what a previous note has said, it is laid down above its namesake. The facilitator will need to group ‘ideas’ rather than exact words together. In this way a ‘bar graph’ of the key ways in which religion contributes to health is created, and the participants can see what they themselves believe to be the key factors.

It is important, however, to keep an accurate record of the diverse answers that are given. The ‘outlying’ ideas are also important, and often point to significant insights.

5.2.4. Task 3: Recorded discussion and input

The facilitator engages with the participants on what is meant by the various factors. The data is probed to gain a deeper understanding of what participants mean.

Input around the idea of Religious Health Assets is contributed to the discussion.

5.2.5. Task 4: Special focus

If there is a special focus to the PIRHANA workshop, this would be the time to introduce it. If the focus were on HIV/AIDS, for example, the facilitator asks:

\[
\text{If the Ministry of Health asked you to identify the two most important ways that religion (including religious people, groups or organizations) contribute to HIV/AIDS treatment, care, and prevention, what would you say? Write these down on two notes.}
\]

In this case only one round is used as participants will have been stimulated by the earlier discussion. The notes are then put up, and the ensuing discussion is recorded.
5.3. Mapping Exercise

5.3.1. Operational information

| Objectives | 1. A vastly expanded set of data about health facilities in the area in the form of a set of ‘corrected’ maps that can then be followed up with GIS mapping  
2. A greater awareness of the presence of RHAs in the community |
| Articulation | This exercise needs to articulate with any further work that is being done around GIS mapping |
| Data | The completed maps and information needs to be kept safe |
| Equipment | • Set of maps for the area – best if copied onto A3 size.  
• These may be of region or local, or both. The maps need to have an accompanying ‘legend’ sheet for data to be written on that relates to numbers that are placed on the map |
| Time | 60 minutes |
| Tasks | 1. Mapping |

5.3.2. Mapping

In groups (divided according to local criteria – possibly geographical location, or responsibility, etc.) participants are asked to verify and add to the facilities that are marked on the maps.

The legend needs to be completed with columns for further data, and then the appropriate number reference placed on the map.

Particular attention is to be given to the marking of specific ‘assets’ for a specific issue that might be focused on such as HIV/AIDS Treatment Programs and broader HIV/AIDS activities.

Participants may carry on if lunch is not ready.

The team member responsible for gathering data should make a note of which maps emerge from which groups.
5.4. Social Capital and Networking

5.4.1. Operational information

| Objectives | 1. To gain a picture of the ‘spaces between’ the entities, the ties, networks, and links  
|            | 2. To gain a picture of the connections to wider institutions and facilities that play a role in local situation  
|            | 3. To get data about important relationships that contribute to the success of RHAs |
| Articulation | This exercise draws on the organisations identified in the time line (exercise 1), and stimulates the discussion about exemplars (exercise 5) |
| Data | 1. The organisational network sheets must be collected  
|      | 2. Photograph of and the original spidergram on newsprint |
| Equipment | • Organisational network sheet  
|      | • Spidergram drawn on newsprint  
|      | • Marker pens |
| Time | 45 mins for individual sheets, 45 mins for spidergram |
| Tasks | 1. Individual sheets  
|      | 2. Spidergram |

5.4.2. Task 1: Individual sheets

Participants work individually or in partnership with those who are representing the same organisation. They have an ‘organisational network sheet’ that enables them to place their organisation in the middle, and to identify the key partners and networks that contribute to the work of their organisation.

The facilitator says:

*We are now interested in understanding more fully the types of relationships that exist among you and your organizations and also among others who may not be with us today. We often think of ‘assets’ as physical things – but in fact, relationships (the spaces between things) can also be an asset.*

*We’d like you to think about your own organisation, and identify the key partners and networks that you have. Place a name in the box, and indicate by means of an arrow the direction of the relationships, and whether it concerns money, personnel or programmes.*

While this is happening, the facilitators prepare the spidergram. This is drawn on four sheets of newsprint, and has a series of circles in a ring around the outside, and a further ring of circles outside of that. The names of all the organisations present are entered into the inner circles, and others are left blank for later.
5.4.3. Task 2: Spidergram

When participants have finished their individual sheets, they are invited to come up to the front and draw only two arrows between their organisation and any other two organisations to represent the two most important relationships. The arrows indicate the direction of the relationships. They may add the names of these organisations if they are not present to the outer ring of circles.

5.4.4. Task 3: Recorded discussion

The facilitator leads a discussion on the networks that exist, probing their contribution to health. This does not involve asking individuals to explain each relationship – but rather to explore the picture as a whole. Questions are asked about why some groups work together, why some do not. Certain nodes of relationships can be recognised and talked about.

Participants are also asked to name and provide links to other significant organisations or entities that are not on the newsprint – whether these are in the local area, wider region, country, or even international.
5.5. Characteristics of Good Practice

5.5.1. Operational information

<table>
<thead>
<tr>
<th>Objectives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. To gain a perspective on what health providers value in religious entities that provide health and wellbeing</td>
<td></td>
</tr>
<tr>
<td>5. To develop a set of criteria for strong Religious Health Assets</td>
<td></td>
</tr>
<tr>
<td>6. To identify key exemplar RHAs in the community</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Articulation</th>
<th>This draws on the previous exercise</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. The index of characteristics</td>
<td></td>
</tr>
<tr>
<td>4. The list of exemplars and any further information that can be gained about them</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equipment</th>
<th>At least two post-it notes for each participant Newsprint and marker pens</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>60 mins</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tasks</th>
<th>3. Key characteristics 4. Identification of exemplars</th>
</tr>
</thead>
</table>

5.5.2. Task 1: Key characteristics

Participants are given two post-it notes, and asked to answer the question:

 acclaim: We’ve looked at a number of organisations today, some are doing better than others. What, for you, are the qualities of a good religious entity contributing to health?

The notes are stuck up. When a note repeats what a previous one has said, it is stuck above its namesake. The facilitator will need to group ‘ideas’ rather than exact words together. In this way a ‘bar graph’ of the key characteristic of Religious Health Assets is created, and the participants can see what they themselves believe to be the key factors. Discussion takes place.

5.5.3. Task 2: Identification of exemplars

Participants are now asked to think about organisations that they know of, and to think two that have the characteristics just identified.

They write the names of these organisations on two post-it notes. In plenary these are placed up on the wall, and the participant explains why each one was chosen.

The specific name and location of the entities that are commonly acknowledged are noted on a spare map for later identification of the GPS coordinates.
5.6. Local Action

5.6.1. Operational information

| Objectives | 3. To ‘hand over the stick’ to local leadership  
|           | 4. To stimulate individual commitment to action |
| Articulation | This exercise draws on the energy of the whole workshop, and particularly the ‘constraints’ that were identified in the exercise 1, the timeline |
| Data | The commitments that are written on newsprint. |
| Equipment | Newsprint and marker pens |
| Time | 25 minutes, with 5 minutes for closure and vote of thanks |
| Tasks | 3. Individual reflection  
|       | 4. Plenary discussion  
|       | 5. Conclusion |

5.6.2. Task 1: Individual reflection

Participants are reminded of the time line. This reminds us of how things can be changed, but also of the wider constraints that face RHAS.

The facilitator says:

≈ In the light of these constraints, given all that you have heard in this workshop, we would like you to think about three ways in which you can make a difference.  
1. For your organisation  
2. By linking to two organisations you heard about today  
3. By contributing to your community as a whole

Participants think on their own and write down these commitments.

5.6.3 Plenary discussion

This discussion is led by local leadership, who are now seen to be taking responsibility for the next moves in the community.

Participants share their commitments, and speak to them. As this happens the facilitators need to be attentive to ideas for action that are emerging about how to mobilize RHAs.

To keep the discussion going, the facilitator could pose the following questions:

≈ What can you do to help the other religious organisations and entities in your community to make a better contribution to health?  
≈ What can you do to help the other religious organizations and entities in your community to make a better contribution to (the special focus issue)
Discussion can continue for as long as is possible amongst the participants before the meeting comes to an end.

It is also important to ask the participants how they would like ARHAP research team to package and return the information gained through the workshop.

### 5.6.4 Conclusion

When the time has come to close the workshop, the facilitators propose a vote of thanks to all who have participated and contributed.