

# Participatory action research in the training of primary health care nurses in Venda

**Van Deventer C**, MBChB (Stell), MCFP (SA), MFamMed (Medunsa)  
Principal Family Physician, Southern District, North-West and Witwatersrand University  
**Hugo JFM**, MBChB, MFamMed (Free State)  
Associate Professor, Department of Family Medicine, MEDUNSA

**Correspondence:** Dr C van Deventer, Address: PO Box 1197, Potchefstroom, 2520  
Tel: 018-2977011, Fax: 018-2947877, E-mail: cvandeventer@nwpg.gov.za

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## Abstract

**Background:** The aim of this study was to understand and be part of a process of change in the training of primary health care nurses in Venda.

**Methods:** Because participatory action research (PAR), which is an emancipatory-critical paradigm, to a great extent shares the same worldview as adult education and sustainable community development, all of which were part of the training process, it seemed the most appropriate research method to use.

**Results:** During the one-year diploma training of the nurses, the nursing students and trainers visited three rural villages, did a survey and held ongoing meetings with the community members in the villages. Qualitative methods were used to understand the nurses' perceptions of the training process. All the time there was an awareness that new knowledge was being created which could be used for the curriculum of the next cycle of nurse training.

**Conclusions:** The results showed that the students had been both empowered and disempowered by the experience. They found it easier to communicate well with the communities they went back to after their training and some problem-based research was spontaneously undertaken by trainees who had been part of the nurse training programme with clinic attenders. However, the nurses also experienced a great deal of resistance from the health system. They wondered whether the whole process had not been biased by them being health workers and felt that they had not had enough access to financial decision making and were therefore powerless to help their own communities with this area of development. New knowledge that emerged was the need to reflect regularly together on any learning process, the parallels in the vocabulary of family medicine and community development and that the financial planning for such a process should be integrated with the other components. *(SA Fam Pract 2005;47(2): 57-60)*

## 1. INTRODUCTION

With the strong emphasis on primary health care in the health system in South Africa since the 1980s, it became important to ensure relevant skills in rural areas. In the northern region of the Northern Province (now Limpopo Province), primary health care (PHC) nurse training had been done for many years. However, the author became more aware of problem-orientated learning and patient and community centredness during her studies in family medicine. In the light of the fact that community involvement in health is of tremendous value and that it is difficult to attain, the process of training was examined together with the nursing students

doing the one-year PHC diploma at the Primary Health Care Education Unit at Tshilidzini Hospital in 1994/1995.

Three interrelated themes kept on emerging, namely **participatory action research (PAR)**, **community development** and **learning**.

## 2. INTERRELATED THEMES

**2.1 Participatory action research**  
Because participatory action research has not been utilised much in health research, some clarification will be useful.<sup>1</sup>

Ramphela emphasises that participatory research should "be distinguished from 'participant

observation' and 'applied research'". Ideally, it should be a two-way process at all levels: "joint identification of the problem to be studied, analysis of the best way of conducting the study; planning the actual work involved; acquiring resources for the study process; implementation; analysis and evaluation of the process; reporting of results; and incorporating the results in future problem solution".<sup>2</sup> There is thus a commitment to total participation. However, there are constraints to this research that are increasingly being recognised. "Some of the major problems acknowledged are the lack of successful models, the impact of the all pervasive authoritarian ethos and practice on most (if not all)

social interactions, the limited capacity of people to form new 'habits of mind' to break free from traditional hierarchical relationships."<sup>3</sup>

There is, however, common ground when concepts such as empowerment, emancipation and political pressure for change are discussed.<sup>4,5,6,7</sup> In community development, participation is encouraged in order to effect real, continuing change that is rooted in people. New knowledge is another key concept and is specifically discussed as ownership of knowledge by the people. Rahman says "it is absolutely essential that people develop their own endogenous consciousness-raising and knowledge generation and that this process acquires ... social power".<sup>7</sup>

The **process** rather than the **results** of PAR plays an important role. Maguire says that "the process of engaging in collective investigation, education and perhaps action may be as potentially empowering as any of the actual knowledge produced."<sup>8</sup> It is therefore necessary to deliberate together about the process. The cycles of action and reflection should be clear from the research and there needs to be sensitivity to new, appropriate knowledge that may be used in future cycles. This knowledge then needs to be **diffused**. One has to be aware, however, that each situation is unique. Rifkin says that "new knowledge is consistently changing the analysis and therefore the application of knowledge. In addition, because this knowledge comes from a specific situation with specific characteristics, this process is rarely generalisable and while it is valid, but it is valid only within the specific framework within which it develops, it is neither representative nor replicable".<sup>9</sup>

## 2.2 Community development

Health and community development cannot be separated and that is why it was so important to consider the process of interaction between nurses and community members in nurse training. Important overlapping ideas

with PAR are the issues of power and control, responsibilities and relationships. In both community development and PAR, the issue of who takes the initiative is important. Karlson identifies the researcher as someone with a separate responsibility and pleads for social verification or validation of the process.<sup>10</sup> This effectively protects the process from the bias of an "outsider". In other words, the group will "devise their own verification system to generate scientific knowledge in their own right".<sup>10</sup>

## 2.3 Learning

Learning, as opposed to "being taught", also has a strong association with empowerment. It was a relevant area to include in this study for future planning for curricula.

All three these themes are very dependent on the worldview or paradigm of the researcher or student or community developer.

## 3. METHODS

The unit of analysis in participatory research is dependent on the understanding of the methodology. It should be a partnership of people who together examine the happenings around them and the significance thereof. In practice, the 10 nursing students doing the PHC course in 1994/5 were the unit of analysis and all the other people, e.g. community members, board members of the PHC Education Unit and others, were kept informed of the process.

*The chronology of the research*  
During the orientation period at the beginning of the one-year PHC course in September 1994, exercises and pre-readings with an emphasis on the above-mentioned worldview were given to the students. In all the previous groups (and in this group), the exercises had led to the desire being expressed that a rural village be visited in order to find out the needs of the people there. The students themselves chose the particular grouping of three villages lying in a valley in the Soutpansberg – a very

isolated area, especially when it is rainy.

In a simple "listening survey", one open question was asked, namely "What is happening here in this village?" This was followed by seven meetings with the villagers over the year that the PHC training took place to give feedback about what had initially been said by them and also to work with them towards some sort of resolution of their problems. One of the students facilitated the meeting in the local language and another took minutes. After a meeting with the villagers, the students and their facilitator returned to the hospital and together reflected on the minutes. This reflection was then documented in a diary form.

Six months after the nurse training was completed, a focus group and two discussion groups were held by the trainer/researcher. The nurses were asked the question: "What happened for you during the year that we were meeting with M?" (the name of the collective villages). This led to further clarification and facilitation. The focus group was videotaped and the other two small group discussions were summarised in writing. Themes that emerged from the transcribed discussions were summarised and later validated by all the participants.

Permission was obtained for this study from the Research and Ethics committee of the Medical University of South Africa (Medunsa), as well as from the nurse participants.

## 4. RESULTS

### 4.1 Chronology

During the initial survey, a number of needs were mentioned by the community members (see Table 1).

A week after this survey, a meeting was held with the headman of M village and he indicated that there was only one problem – the fact that there was no clinic. Once a clinic had been built, according to him, all the other things would follow, e.g. telephone lines and proper roads. This perception was later echoed many more times by others. After receiving no further

**Table 1:** Comparison of prioritisation of needs by community versus students

Community's perceived needs	PHC nurses' perceptions of needs
1. Clinic (health services accessibility) <ul style="list-style-type: none"> <li>• children</li> <li>• immunisations</li> </ul>	1. Clinic accessibility
2. Transport <ul style="list-style-type: none"> <li>• Taxi stop at Maranzhe (<math>\pm</math> 4 km away and very hilly terrain)</li> <li>• Cut off during rainy times</li> <li>• Roads in very bad condition</li> </ul>	2. Electricity
3. Café far – difficult to get fruit/vegetables and food	3. Transport/roads
4. No telephone or radiophone	4. Café
5. Inadequate bridge	5. No food parcels
6. School – especially for small children <ul style="list-style-type: none"> <li>• because of river they cannot go in rainy weather</li> <li>• children start school late because of distance</li> <li>• Maranzhe School already over full</li> <li>• truancy high</li> </ul>	6. Personal hygiene
7. Electricity needed	7. No crèche
8. Butchery needed	8. Naked babies
9. Water-supply problem/not purified	9. School
10. Sports ground	10. Only one church at the top village and two at the bottom villages
11. Primary health care team not reliable	11. No care group
12. Flooding during rain time	12. Few personal vegetable gardens
13. Khoro meetings not easily accessible	13. Eye problems
14. Unemployment	14. Beer cans? shebeen

invitation to the villages after five weeks, a visit was made by the nurses and a Sunday in November was negotiated with the headman as a meeting date. The results of the survey were explained by one of the students on that day during the meeting, which was held on the mountain. It was decided by the people of M to include the inhabitants of another two nearby villages at a following meeting. As the unit of analysis remained the PHC students, they were asked to write about the process after this visit. The following emerged:

- Their feelings: "I feel good"; "they will reach their goal"; "I doubt solving these problems will be possible"
- Their perceptions: "have the vision to develop their village"; "have one thing in common"
- Their discoveries: "found that people open up very much when they are visited at their place ...

two-way communication is easily practised"

The next visit was held under a large wild fig tree. It was joined by other resource people, namely a community developer and engineer. One of the headmen was very intoxicated and disrupted the proceedings continually, but negotiations were started on choosing a committee and the eventual building of a clinic. During subsequent meetings, attempts were made to introduce some PAR methods, e.g. a timeline and mapping, but these did not work as expected. Instead, the graphs were turned into stories that included the history of the area!

In the following meetings, relationships were built, a committee was formed and a great deal of practical work was done that exceeds the scope of this article. A very important result that was not part of the primary outcome was the fact that

the clinic was eventually completed with donated money and is functioning fully after it was incorporated into the public service.

#### 4.2 Nurses' experiences on completing the course

After the nurses had completed the course and returned six months later for the focus and discussion groups, two main themes emerged, namely feelings of empowerment and disempowerment. These were significant, as PAR is used most commonly as an empowering tool. These themes also confirmed what had been discovered in the reflection sessions after the meetings.

##### *Empowerment:*

- As a result of exposure to the dynamics of rural villages, some directly-related feelings of empowerment were experienced: "I feel free to speak in front of a

'khoró' (community gathering) now whereas I would never had done so before"

- One nurse initiated a number of activities at her local clinic and research projects including a geriatric fun run and a high school survey on suicide attempts linked to a plan to help teenagers in the area, together with their parents
- The nurses also felt that they had learnt respect for the opinions of rural non-professional people

There were a few personal spin-offs, where nurses decided to make career changes because they felt challenged by the changes a rural community could make.

#### *Disempowerment:*

- The health system did not allow innovation and did not regard "community involvement" as part of a nurse's job description. There was a barrier from management structures when the nurses wanted to initiate something like this
- Certain skills, e.g. fund raising and working with donors, were not addressed during the process of the research. Nurses were afraid to start something and then let the community down due to lack of knowledge about finances
- It was felt that the priorities chosen by the community were "influenced by the fact that we were health workers"

#### 4.3 New knowledge recognised

The new knowledge that emerged in reflections between the nurses and the trainer in the course of the year and that was captured in diary form included the following:

4.3.1 Some family medicine principles were found to be relevant in discussing the process that had been experienced. Community-centred care reflects a number of the principles of patient-centred care, e.g. respect for the patient's (community's) agenda, networking between different professionals, e.g. engineers,

architects and community developers, and the crucial role of the management of resources.<sup>11</sup> The latter was very relevant when we were faced with the management of donations. The students were inadvertently excluded from this as it had not really seemed relevant to learning at the time.

#### 4.3.2 How does learning really take place?

According to Rogers, "much significant learning is acquired through doing" and is facilitated when "the student participates responsibly" and "when the subject matter is perceived by the student as having relevance for his own purposes".<sup>12</sup> There was responsibility and relevance, as well as self-directed learning and facilitation, rather than lecturing in the process that was followed.

The importance of regularly discussing the process of learning with the students was also recognised.

#### 4.3.3 The potential of stories

The timeline given to the villagers to do was presented to us as a story rather than a chart. Whilst a timeline concentrates on the past and present, a story can also reach into the future and this is very promising for harnessing hope and change.

## 6. Discussion and conclusion

A difficulty throughout was keeping the unit of analysis clear and concentrating on the learning and empowerment of the PHC nurses, whilst also appreciating the importance of the community's agenda. The methodology itself also presented the difficulty of deviating from quantitative methods, as it was not measurable, being more subjective, and often even philosophical. This makes it more difficult to document the process in a meaningful way.

Working with communities seems to need a commitment to a certain worldview, namely one that accommodates participation from all role players, understands learning as an experiential process and can see the value of community-based research.

There are aspects of the research that warrant further attention, namely the extent to which there has been a change in practice by nurses returning to their clinics after the course, the role of storytelling in community development and the role of PAR methods.✎

## Conflict of interest

There are no conflicts of interest to declare.

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