

Comprehensive Participatory Planning and Evaluation (CPPE)

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Introduction

This article introduces Comprehensive Participatory Planning and Evaluation (CPPE), an approach to community participation and empowerment developed from the work of Rifkin,^{1,2} Laverack,³ Pérez,⁴ and others. More than just a methodology, CPPE is an approach which encourages comprehensive analysis and participation by various actors at local, regional, and national level in the planning and evaluation of health actions.

CPPE has its roots in the 1980s, when an international team of researchers from the Institutes of Tropical Medicine in Antwerp (ITM-Belgium) and Amsterdam (KIT-Netherlands) developed a framework of comprehensive participatory evaluation for nutritional improvement programs. Following its initial application in the Philippines, further work extended the evaluation approach to planning. CPPE was gradually refined with the support of research teams in Indonesia, the Philippines, and Brazil⁵ as they applied it in different contexts and projects.⁶ Since 2008 projects have been carried out in Cuba to analyze the possibilities offered by CPPE for increasing community participation in health.

This article illustrates the rationale and tools employed in CPPE through our experience in Cuba in the urban municipalities of Centro Habana and Las Tunas and in a rural community in the mountains of Cumanayagua. We discuss key methodo-

logical components, the conditions needed for the success of CPPE, and potential differences between the Cuban experience and the possible application of CPPE in other contexts.

CPPE methodology

We consider genuine participation as a process of developing a community's capacities to identify its needs and then to generate proposals and initiatives which defend its interests. This is a gradual process. Consequently, CPPE takes place in a cycle: planning, implementation, and evaluation, followed by a new stage of planning. Periodic evaluation—perhaps annually—is carried out to assess progress on planned initiatives and the level of local organization. In each cycle community situation is reassessed and plans updated for the following period.

Stage I. Planning workshop

The central activity of CPPE is a workshop which lasts about four days. This duration is flexible but sufficient time should be allowed for development of the various stages, supported by the suggested tools. (Figure 1)

A proper diagnosis is essential to planning; general community issues—including health problems— have multiple causes and typically involve various sectors. A diagnosis is elaborated using a *causal model* which allows potential interventions to be identified. A *selection table* with defined criteria (importance of the problem, feasibility, cost-effectiveness, sustainability, etc.) can help participants select the most appropriate interventions by consensus. Three tools can then be used consecutively to develop operational plans for each selected intervention:

1. The *HIPPOPOC* table identifies *Inputs, Processes, Outputs, and Impacts*;
2. The *dynamic model* makes explicit the rationale for the set of activities proposed and how they come together in the proposed outcome, and:

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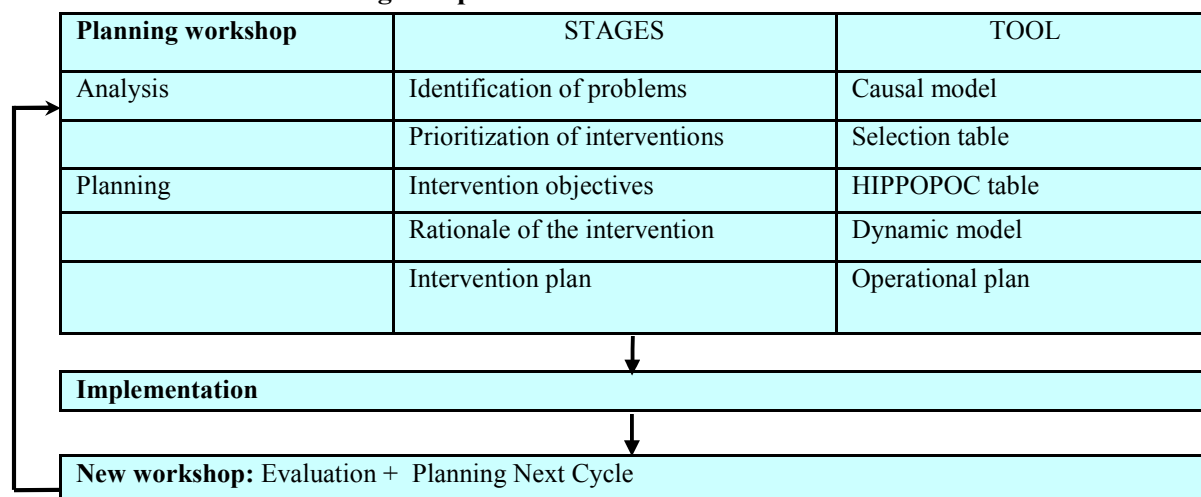
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Figure 1: CPPE rationale
Planning—Implementation—Evaluation—Plan Revision



3. The *operational plan* (what, when, who, what with, and with whom).

The planning stage should produce three results: 1) improved understanding of the multiple causes of the problem to be tackled, 2) a consensually agreed upon intervention plan, and 3) a trained and committed work team.

Stage II. Implementation of the interventions

Implementation follows the plan that was formulated at the workshop and is led by the work team. Continuous feedback on the plan’s progress and problems is provided to all team members and to the community as a whole. This is essential for fostering the dynamic of community involvement.

Stage III. Evaluation

After the implementation phase, the team reviews the results in an evaluation workshop; this will involve both evaluation and further planning. Strengths and weaknesses are identified and solutions developed for the problems encountered during the preceding period.

Each follow-up workshop begins with an assessment of what has been accomplished using the dynamic model developed the previous year. This allows participants to ask pertinent questions in three domains:

1. What were the immediate results of the intervention?
2. Are the objectives relevant? (e.g. were the objectives appropriate? Do the interventions remain relevant?)
3. How well was the project implemented? (Did we manage to include more people?)

Were we able to strengthen grass-roots organization in the neighborhood?)

Following this discussion, the team prepares a consensus evaluation looking at what worked well. They also examine where and why problems arose. This information serves to inform a review of the previous year’s causal model. The model is revised to take into account how the community has changed and the lessons it has learned during the previous year. Interventions proposed for the new cycle can be either amendments or extensions of the previous year’s work plan or completely novel. (Figure 1)

Fifteen to twenty people are involved in the planning workshop. To the extent possible they should reflect all community stakeholders. This includes leaders of civil society and grass-roots movements as well as local representatives of the various public sectors (health, education, municipal services, farming, etc.). We also include informal community leaders such as young activists, the local hairdresser who knows everyone, housewives who care about the neighborhood, etc. The idea is to involve all groups who can contribute to local (health) planning; this ensures their commitment to project implementation.

Three years’ experience in Cuba

CPPE was first applied in Cuba in 2008. The methodology had been developed initially for planning projects carried out by international NGOs and other organizations and had to be adapted to community work within the context of a local health system.⁷

Table 1: Synopsis of Work in Cuba (2008-2010)			
Location	2008	2009	2010
<i>Dragones</i>	Planning & Implementation	Evaluation (of the previous year), Planning & Implementation	Evaluation (of the previous year), Planning & Implementation
<i>Sierritas</i>		Planning & Implementation	Evaluation (of the previous year), Planning & Implementation
<i>Las Tunas</i>		Planning & Implementation	Evaluation (of the previous year), Planning & Implementation

The Cuban government has constructed a policy framework which has enabled substantial progress in population health over the last 50 years.^{8,9} Local health services have developed many linkages with community organizations.^{10,11,12} Many projects have managed to avoid the risks of paternalism and bureaucracy by developing truly participatory styles of leadership.^{13,14,15} However, in general the results of community participation in health have been somewhat mitigated. Opportunities to allow for participation in health decisions are not fully exploited. Local health planning does not consistently involve other social sectors nor does it always include participation by formal and informal community leaders.¹⁶

In collaboration with the Institute of Hygiene and Epidemiology (INHEM) and the Cuban Ministry of Health, we set out to find ways of addressing these problems. We hypothesized that greater community participation in planning and evaluation would lead not only to more realistic and feasible plans but also to more active, sustained community participation in the implementation of the proposed interventions. The result, finally, would be improved health outcomes. Increased participation reinforces a sense of community ownership of health activities which, indirectly, ensures that these initiatives are more sustainable.

Three municipalities were involved in this first stage. *Dragones* is located in the Centro Habana municipality of Centro Habana, a commercial area within the capital city. With 30,000 inhabitants in 0.5 km², it is one of the country's most densely populated areas. *La Sierrita* is located in the center of Cuba in the municipality of Cumanayagua, province of Cienfuegos. This is a rural area with nine working-class settlements at the foot of the Guamu-haya mountains. The main economic activities are cattle-raising and coffee-growing. People's Council No. 5 is in the municipality of *Las Tunas*, capital of *Las Tunas* province. With a population of 25,000, it forms an urban area in the eastern region of Cuba. The main economic activity is small industry.

By the end of 2010 seven workshops had taken place (one in 2008, three in 2009, three in 2010) covering four full planning—implementation—evaluation cycles; three cycles were in progress.

Examples of the methodology in Cuba

The various steps of the CPPE methodology can be illustrated using the models and plans developed in Cuba.

In order to select interventions a *causal model* is built based on an analysis of community problems. (Figure 2) During a brainstorming session, participants identify the main causes which ensure or affect health in their neighborhood or community. First the direct causes of potential problems are determined, followed by an exploration of the factors which favor these causes. Depending on their particular needs, participants can subdivide certain parts of the model for further in-depth analysis. A full causal model can be quite extensive. Figure 2 shows one part of the analysis of neighborhood cleanliness undertaken in *Dragones*, viz. how the behavior of the inhabitants affects cleanliness.

A lack of comprehensiveness is a recurring problem in program planning and evaluation; this can have major consequences. Proposals risk not being applicable because they do not take into account a series of existing conditions and sensitivities. CPPE can help reduce these risks because the causal model helps explore the complexity of the problems and identify possible solutions. Discussion makes for better understanding of how different people have different perceptions of the problem. This enables group identification of core targets for intervention.

In principle the team works with available information. Most elements of the problem can be identified using the participants' pre-existing knowledge. Some causes can be put forth as hypotheses and, if necessary, verified with additional information (quantitative and qualitative) before proceeding with the planning stage.

The *ranking table* is used to select interventions. Participants define selection criteria: the importance of the outcome, its weak points, the potential to reduce inequities in the community, the degree to which participation is fostered, etc. The participants then choose the most appropriate interventions to solve the selected problem. With the ranking table, each criteria is analyzed to see if it applies to the proposed intervention, using grades High (H), Medium (M) and Low (L). Bearing in mind the prioritization criteria, those interventions with the greatest number of High and least number of Low grades are highlighted. The selection table ensures consistent focus when selecting possible interventions and helps reach agreement among participants on manageable proposals. Table 2 demonstrates how proposals to make a healthier neighborhood were ranked. Once the ranking is complete, the group decides which interventions should be carried out.

The first step of the planning stage is to identify what is needed to implement each individual intervention. To do this *HIPPOPOC** table is made up. *Inputs (IP)* are the elements necessary for implementation of the intervention (e.g. budget, material resources, human resources, etc.). *Processes (P)* refer to the actions which must be undertaken to achieve the desired result. *Outputs (OP)* are the immediate results of these actions while *Outcomes (OC)* are changes induced by the project. *Figure 3* shows the HIPPOPOC table which was completed for a project reorganizing street sweeping in Dragones, Centro Habana.

The following step, the *dynamic model*, represents the core of the planning stage. The dynamic model provides a graphic representation of the logical progression of the project. (*Figure 4*) It represents how participants visualize the project developing from the inputs, through a succession of processes, to achieve operational objectives (the intervention's outputs) and finally the desired outcomes, directly related to the intervention) and finally the desired impacts. The dynamic model is constructed from right to left, beginning with the impacts, then the outputs, the processes and—on the left—the inputs. Sometimes, during the elaboration of the dynamic model, it is necessary to go back and revisit the HIPPOPOC table. This is perfectly acceptable.

This approach makes it possible to identify the crucial steps in project implementation. It clarifies the sequence of activities and allows for structured monitoring and evaluation during project implementation.

* (H)-IP-P-OP-OC: Inputs-Processes-Outputs-Outcomes

In the final step, estimates of the time needed to complete each activity are noted in the model either within the activities box or along side the arrows. (*Figure 4*) Having completed these steps, it is now time to prepare for the operational stage.

Once a consensus has been reached on the overall process, participants translate the model into an *operational plan* which delineates activities, resources, implementation dates, and responsible persons. This plan must provide detailed answers to the basic elements such as: What? Who? Where? When? With what (resources)? Why (evaluation measures)? (*Table 3*) Lastly, participants nominate a coordinating team which is responsible to ensure the plan is followed.

Initiatives in the period 2008-2010

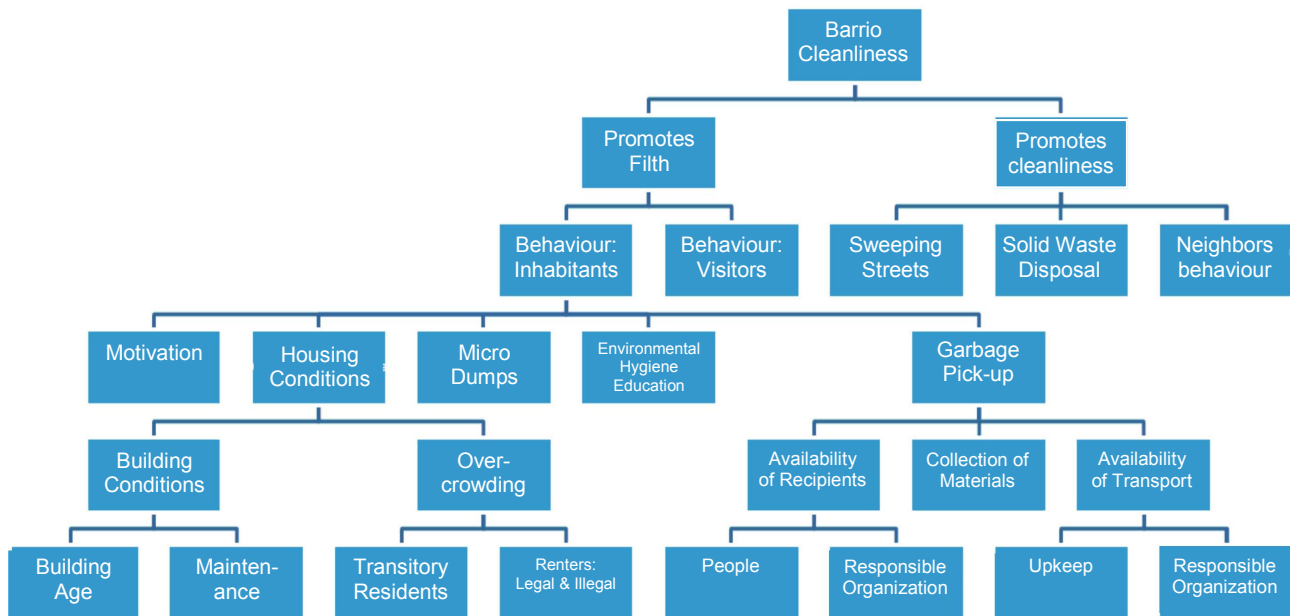
In Dragones, Centro Habana, three CPPE cycles have already taken place, and the process now has considerable momentum. In part, this is because participatory projects had already been undertaken in Dragones; the pre-existing community center maintained and strengthened its leadership. Thanks to CPPE, a greater and more diverse popular involvement was achieved. The consensus among the extended coordinating group is that the method allowed them to be better organized. They managed to work more systematically and with greater involvement by individuals. Coordination with local government also improved.

In Cumanayagua and Las Tunas too, community participation and local initiative were both enhanced. However, these communities had less previous experience in community participation. Only two years into the project, results in these two localities are not as far-reaching.

As detailed below, some activities were undertaken by either the health services or some other branch of the municipal government with only limited community involvement. Other initiatives managed to develop genuine forms of social care or changed hygienic / social health determinants with the community playing a prominent role. The vast majority of those involved directly or indirectly in these processes confirmed their satisfaction and enthusiasm with the level of engagement they themselves felt had been developed.

Even with a favorable context and committed individuals, participatory processes are not linear. They require time to evolve and there are moments of both progress and retreats. These processes cannot be forced; the dynamics of community engagement foster growing consciousness of the most appropriate organizational forms. CPPE merely offers a structured way for this constructive process by

Figure 2
Causal model (Example): Neighborhood cleanliness, Dragones, Centro Habana (2008)



which a group of people formulate plans with increasing participation and comprehensiveness.

Here we present some of the initiatives which took place over the period 2008-2010 as part of local health interventions planned in CPPE workshops.

“Model street” and the reorganization of street-cleaning

In January 2008 the first CPPE workshop took place in Dragones. The thirteen participants included six formal and seven informal leaders. Seven were female. Participants ranged in age from 20 to 70. The informal leaders included retirees (two) and a student, a housewife, a public employee and a self-employed resident. Formal leaders included

two representatives of the health sector, the president of the People’s Council (local government), a representative from municipal services, a representative of the Municipal Housing Office, a nurse at the community center, and a physician.

Dragones has a population of 30,000 inhabitants. However, because it is a commercial center some 60,000 people visit Dragones each day. With so many people the cleanliness of the neighborhood is a constant concern and was chosen as a priority issue. Participants decided to tackle the issue by reorganizing street cleaning with greater community support and creating a “model block.” A block was chosen to initiate neighborhood cleaning activities. Within a short time, residents of three neighboring blocks decided to join in. Towards the end

Table 2:
Ranking table: Proposals for Improving Neighborhood Cleanliness in Dragones*

Criteria	Reorganize street sweeping	Model block	Monitoring by community	Permanent commission	Collection of raw materials	Education of the public
Outcome	H	H	M	M	L	M
Organizational feasibility	M	M	M	H	L	M
Financial feasibility	M	M	H	H	L	M
Technical feasibility	H	H	H	H	L	M
Community participation	M	H	M	L	M	H
Sustainability	H	M	M	L	L	M

Legend: H means a “high” score; M a “medium” score, and L a “low” score.
 *This table is offered as an example of how ranking tables are used.

Figure 3 HIPPOPOC table: Reorganization of Street Cleaning with Greater Community Participation			
Inputs	Processes	Outputs	Outcomes
<ul style="list-style-type: none"> • Work equipment: brooms, shovels, gloves • Street cleaners • Minimum budget for material incentives • Materials for educational work • Community human resources • Time 	<ul style="list-style-type: none"> • Information to the community about street sweeping reorganization by district • Meeting with municipal specialists • Proposal to the Municipal Directorate of Community Services • Proposal to the Provincial Directorate of Community Services: <ol style="list-style-type: none"> 1. Meeting of all sectors involved in the project 2. Create an emulation system 3. Involve the youngest through educational talks 4. Involve the whole community 5. Incorporate work centers 6. Promote the project through educational talks, transmission of messages in the districts 7. Seek solution to micro-dumps 	<ul style="list-style-type: none"> • Reorganized street sweeping • Clean streets • Community awareness of the importance of neighborhood cleanliness • Adequate environmental hygiene 	<ul style="list-style-type: none"> • A healthier life • Improved health

of 2008 an additional two blocks had been incorporated.

The model block program was particularly successful in terms of community action. Volunteers cleaned up their blocks and made them more attractive. This was a joint effort between the community, the health sector, and the municipal government. The initial leadership came from the health sector; this changed as the project continued. A culture of collaboration developed in which the community played the major role; between 50 and 80 people took part in each of the activities.

In order to repairs the façades and houses in the model blocks, the municipal government provided residents with cement, paint, doors, windows, etc. An agreement was negotiated so that 80% of the resources were government-supplied and 20% were provided by the community. Project activities were characterized by spontaneity and a spirit of collaboration among residents and activists from local organizations.

In addition to cleaning and beautification, health promotion and prevention activities took place. Recreational and sporting activities drew big crowds.

The second CPPE workshop (2009) decided to extend the “model block” project by creating “model streets.” At the initiative of the community materials were provided to undertake home repairs. All materials were stored at designated sites and guarded by the neighbors themselves. Someone was chosen to distribute the materials according to an agreed-upon list of needs. The individuals cho-

sen for this position were replaced twice because of community dissatisfaction.

Local artists from different disciplines were incorporated into the project. They helped decorate the streets, designed community logos, held workshops, and organized exhibitions.

In December 2009 local government—which had actively participated in these activities—decided to give the project a workspace. At a meeting involving all community leaders a Community Center for Neighborhood Development was created. Its purpose was to promote community participation in the solution of local problems.

In February 2010 the third workshop took place. The evaluation noted that community participation in project activities was gradually increasing. A decision was made to focus on issues affecting “Neighborhood Health.” The result was a reorganization of family medical practices in order to strengthen the relationship of the health teams with the community. The plan includes using volunteers to renovate the clinics, a discussion concerning the roles and functions of health teams, health promoter training, the identification of learning needs, and a proposal to proclaim these practices “model medical practices.”

From January 2008 to date (end of 2010), fulfillment of the operational plan has been analyzed in monthly meetings; these have been attended by community members and representatives of the various municipal institutions. Attendance has been high. The current coordinating group includes all its original members as well as additional, more recent recruits

*The Experienced Youngsters Social Club**

In 2009 the Las Tunas community decided to create a comprehensive program for the elderly. There had been a similar program in the past but it had fallen into serious decline. It was decided to renovate a space for social activities and talks. Work centers were recruited to provide lunches for elderly people who lived alone. Both formal and informal social care networks were set up to help needy nuclear families. Elderly people from other districts got involved in the workouts (gym, club) and social activities of the Club. It evolved into a movement of friends which has spread throughout the municipality. The active collaboration between the population and different sectors of the municipal government has been most beneficial for the elderly.

In April 2010 Las Tunas created an environmental program: “A Community of Gardens means a Health Community.”[†] The aim is to involve families and work centers in the cleaning and planting of yards and plots of land.

Health convoys

The rural area of Cumanayagua had more limited results with CPPE. The group decided to organize health convoys to isolated mountainous settlements. The goal was to provide these remote areas with better access to prevention and health promotion campaigns, general medical and dental care, and clinical laboratory services. Three training sessions were held for health promoters, who then replicated the trainings in schools, work centers, community centers, and settlements. In 2010 the initiative was expanded to include more sustained follow-up of chronic patients.

These programs primarily involved the health sector; there was relatively little input from the community itself.

Discussion on methodological approach

The application of the same tools in different contexts provided important insights. In general, the best results were obtained where the CPPE rationale and conditions were most closely respected. But even errors helped clarify certain methodological questions. Below we present some of the lessons learned.

Rationale and sequence of the method

It is important to complete all steps without omitting any of the stages. There may well be other, possibly better ways of performing the analysis of

the situation, selecting interventions and planning them in a structured manner, but each of these stages is required. The tools reinforce a systematic approach and ensure everybody’s participation.

The time required for each stage can vary. In our experience a workshop never lasts less than four days. Two days are needed for analyzing the problems and selecting interventions, and an additional two days are required for developing the rationale of the intervention and formulating the plan. This initial work results in some time savings for later workshops. However, additional time is needed later on for evaluation. If workshops are too short, the various objectives will not be met in terms of the analysis and the plan, nor will it be possible to build a stronger team to ensure follow-up and mobilization throughout the year.

The collective planning process must be based on the specific realities of the location; it needs to take into account existing possibilities and limitations in terms of people, resources, and time. As community leaders become more capable of taking initiative, community empowerment is strengthened and the organized community establishes more effective links—at times collaborative, sometimes conflictive—with government sectors.

Iterative work involving regular evaluation and (re-)planning workshops—annual ones work best in our experience—helps to maintain mobilization over time. Every workshop serves to renew interest in participation and mobilization.

Participants

Familiarity with the local area is essential to ensure that formal and informal leaders truly represent the various informal groups within the community. Participation by representatives of the various community stakeholders ensures the pluralist nature of planning and evaluation.¹⁷

Pluralist approaches have been studied in the evaluation of state-run activities in the United States and Europe at the end of the 80s, (e.g. in evaluating improvements in underprivileged neighborhoods).^{18,19} In the Cuban context the presence and commitment of formal sectors of local government is relatively easy to obtain. There are no fundamental contradictions of interest between working-class sectors and the State. Institutions understand their responsibility towards community health and its determinants.

But nothing is ever quite so simple. Over the years we have seen what happens when the methodology is not followed. If a local government representative cannot discuss matters with residents as an equal, this hinders development of any proposal. Similarly, if a leader comes along with a pre-set

* *Club Social Juventud Acumulada*

† *Comunidad sembrada, salud garantizada*

Figure 4: Dynamic Mode: Reorganization of Street Cleaning (Example)

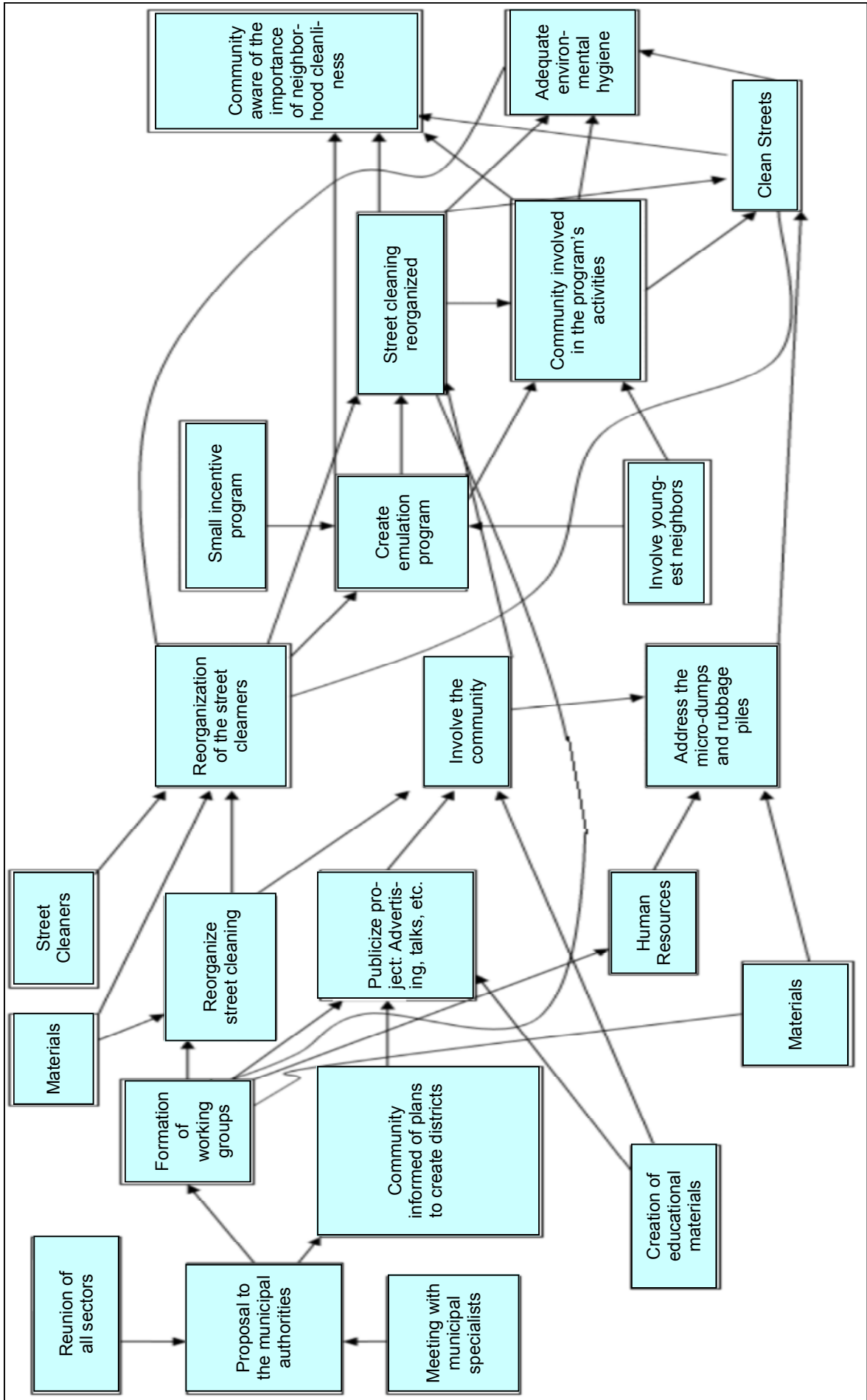


Table 3
Operational plan (Example): Reorganization of Street Cleaning with Popular Participation

WHAT	WHO	WHERE	WITH WHAT	WHEN	INDICATORS
1. Choose a block	People's Council (PC) PC President Grass-roots organizations	PC headquarters	Human resources (HR)	02/2008	Block selected
2. Coordinating group	People's Council (PC) PC President Grass-roots organizations	PC headquarters	HR	02/2008	Coordinating group created
3. Promote the project	Commission created at the level of the PC	Block selected	HR, leaflets, TV	03/2008	# of bulletins, leaflets and banners made
4. Create a guide for community work	Health educator	Department of health promotion	HR and material resources (MR)	03/2008	Guide created
5. Renew neighborhood council to oversee the work	Grass-roots organizations, formal (FL) or informal leaders (IL)	Block selected	HR	03/2008	Neighborhood council created
6. Training workshops	Health educators for local residents and health promoters	Dept. of health promotion and community center	HR, TV, leaflets, videos, murals	03/2008	Number of workshops completed
7. Presentation of proposal to the community	Mass organizations and leaders (FL & IL)	Block selected	HR, videos, murals	03/2008	Proposal submitted
8. Resume voluntary work	Neighborhood council and the community	Block selected	Cleaning utensils	04/2008	Number of voluntary jobs
9. Workshops for children and teenagers on hygiene / prevention	Health educators	Community center	Videos, teaching materials	05/2008	Number of workshops and number of participants
10. Resume CDR emulation [needs a brief explanatory footnote provided by Cuban authors]	Mass organizations	Block selected	HR	02/2008	Emulation system created
11. Motivate neighbors for common fund for activities	Neighborhood council and coordinating group	Block selected	Financial cooperation	03-04 /2008	Fund in existence
12. Undertake sporting, recreational and health activities	Coordinating group, neighborhood council and community	Block selected	HR, sporting implements, bulletins, leaflets	Quarterly	# of activities # of participants
13. Ensure proper sweeping of streets	Neighborhood council and all neighbors	Block selected	HR	Permanent	Clean streets
14. Place collection baskets	District service	On the street	HR, baskets, building materials	03/2008	Collection baskets placed
15. Make and put up signs	Neighbors on the block	In the area	HR, teaching materials	04/2008	Signs put up
16. Ensure care and maintenance of waste containers	Neighbors on the block and district service	Block selected	HR, MR	Permanent	Containers in good condition
17. Program 'tareco' scheme (disposal of useless objects)	Neighborhood council, coordinating group and district services	Block selected	HR and transport	Monthly	Number of 'tareco' schemes
18. Involve job centers and medical practices	Neighborhood council and coordinating group	Block selected	HR	04/2008	# of job centers incorporated # of medical practices incorporated
19. Cleaning of storm drains and sewers	District service and neighbors on the block	Block selected	Technical means	Permanent	Number of clean storm drains and sewers

agenda and is not open to discussion, nothing can be accomplished. The presence of somebody with an authoritarian attitude can lead to denial of real, existing problems. If these glitches are not overcome, the team ends up disbanding. In our experience the methodology is generally sufficiently flexible to resolve these types of tension or conflict.

Facilitation

Facilitation is designed to ensure the smooth running of the workshops. The facilitator must be familiar with the methodology in order to adapt the tools to local conditions and needs. He or she should ensure that frank and open discussion can take place; this may involve countering any "strong

personalities.” Conflicts are inevitable in this type of workshop; in fact, they are healthy. If well managed, conflicts offer the opportunity to deepen understanding of a problem and find better solutions. The consensus reached following debate will always be better than the original proposal.

One discussion on medical care in a neighborhood began with the (superficial) conclusion that “all is well.” Eventually one resident brought up a series of criticisms, contradicting one of the formal leaders. Following the timely intervention of the facilitator, the leader was able to (re)learn that true social commitment does not consist in minimizing problems, but rather in investigating them thoroughly and mobilizing the community to resolve them. From that point on, the discussion opened up much more, furthering understanding of the problems. The facilitator had performed her role properly.

The facilitator is perhaps the most important person in the workshop. He or she must ensure that everybody has an equal opportunity to participate. By actively listening and asking questions, facilitators show the group that each person’s contribution is important, helping everyone develop communication skills and promoting discussion. In this regard the facilitator also plays a key role in building a team which can lead community work. Appropriate facilitation reinforces this person’s leadership. They must have the capacity to listen, summarize, mobilize, and bring more people into the action and to the local organization.

Selection of the facilitator is crucial. They can be a community member or someone from outside. Even if the facilitator is from the community, he or she must be neutral regarding participants’ opinions.

It is necessary to spend enough time for preparation of the workshop and to get to know the community’s background. If the facilitator is from outside the community, a preliminary introduction to the situation consists of reviewing relevant documents and holding interviews to obtain information from those involved in the community and its institutions. In this way the facilitator gains differing perceptions about the nature and magnitude of the problems and their causes. He or she learns of possible interventions already present in the area and identifies potential participants in the workshop who could assist with in-depth analysis.

For facilitation to work, it is important to clearly explain the objectives and methodology of each step. Time needs to be set aside for questions. It may be necessary to repeat these steps until everyone is in agreement. It is important to check fre-

quently that everyone is following the progress of the workshop. All participants should be treated as equals, be they Mayor or housewife. It is essential that the facilitator not take sides or actively take part in discussions among participants, although he or she can always suggest alternatives. For the workshops to run smoothly, the schedule should not be too flexible. Lastly, it is important for a community not to keep changing facilitators from year to year. If a change is necessary, it must be well prepared for.

If the objective is to reinforce and extend this participatory method, then facilitator training is a core task. In Cuba we are preparing a facilitator training program and have produced a facilitation guide. But workshop training has its limitations; facilitation cannot be learned by theory alone. The skill is gained only by taking part in workshop facilitation in the community.

Conclusions and outlook

Three years’ experience has demonstrated the potential of this methodology to promote participation and empowerment in the Cuban context.²⁰

In putting the right to health into practice, there is a synergy between the Cuban State and grassroots organizations. A variety of organizations (women’s, workers’, youth, neighborhood, etc.) have made and continue to make significant contributions to the transformation of the country.²¹⁻²⁵ The political nature of the State and the actions of local government lead to closer popular identification with social policies despite existing material constraints and deficiencies. We hope to continue this work in Cuba over the next few years, and to continue learning. Additionally, in coordination with the Ministry of Health and with support from PAHO and the Belgian NGO INTAL, facilitator instruction is being extended with the hope of ensuring adequate levels of training in this essential resource.

CPPE is a comprehensive method of participation which requires and enables the free discourse of participants and in-depth group discussions. This leads to increased self-esteem and self-fulfillment, as well as greater commitment to the community. CPPE is very flexible in that it can be applied to a wide range of situations (services, programs and projects) and at various levels (national, regional, municipal and local). During 2010, in a study of social determinants of neglected diseases and other poverty-related illnesses in Yucatán, Mexico, we introduced CPPE as a method of participatory research. We demonstrated that for any community intervention it was imperative to directly and ac-

tively involve communities in analyzing their reality and in proposing measures and interventions affecting their own lives. We also showed that CPPE can be an appropriate tool to do this²⁶. In mid-2010 an exchange was begun with the People's Health Movement-Latin America (PHM-LA) about experiences in participation and empowerment in order to continue learning and participated in strengthening this movement.²⁷

The right to health in other contexts

The Cuban State's policy on health, despite any constraints it may face, is based on defending the right to health of all Cubans. To achieve this objective there exists a synergy between the State and grass-roots organizations.¹³ In countries where there is a major gap between the interests of the elites which dominate public institutions and the needs of communities, any negotiation or search for consensus on how best to move forward in exercising the right to health inevitably confronts important limitations. In these cases, claim-holders seek other ways of pressuring the political authorities (duty-bearers) to listen to them and respect their rights.¹¹ Through demands and protests they seek a more advantageous negotiating position. In these "other" contexts—where there may be a greater conflict of interest between state and society—this same planning exercise can help communities identify real contradictions, better understand to whom they should address their demands, and how to progress towards the realization of their right to health.

A rights-based approach does not simply mean the right to something. It implies the possibility and obligation to claim this right from those who have the power and duty of ensuring it. This involves a strategy of community empowerment. The planning exercise can be set up to see how best to defend popular interests or conquer (a share of) power.

The concepts of obligations, duties, and responsibilities of the State are crucial to community empowerment. They allow it to make demands and negotiate the necessary changes with those who are in power. If those responsible do not act, group action might be necessary before success is achieved.

On the other hand, nobody can be held responsible if conditions make it impossible for them to comply. The person must first accept responsibility, have the necessary authority to act, and have access to and control over resources. A "capacity analysis" can clarify which individuals or institutions should and can act in each of the actions required. The result can be an appendix to the proposed intervention plan, listing key individuals or institutions to carry out the proposed objectives.²⁸ This capacity

analysis can be an important complement to CPPE since it focuses social mobilization on the relevant governmental authorities. To the extent that more communities and organizations are successful in demanding their rights, the movement for the right to health becomes stronger and more successful.

Practice will continue to enrich this approach as it is applied in diverse situations in different countries, regions, and locales. When circumstances allow, this collective planning exercise not only leads to greater commitment and better organization at grass-root level, but also to greater political awareness.

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References

1. Rifkin S. Equity, empowerment and choice: from theory to practice in public health. London School of Economics, United Kingdom. Presentation made at Forum 9, Mumbai, India, 12-16 September 2005.
2. Rifkin S, Pridmore P. *Partners in Planning*. London: Macmillan, TALC. 2001.
3. Laverack G. Using a domains approach to build community empowerment. *Commun Dev J* 2005. (www.oup.co.uk/journals/cdj/advance, accessed on 11 March 2005).
4. Pérez D, Lefèvre P, Romero MI, Sánchez L, De Vos P and Van der Stuyft. Augmenting frameworks for appraising the practices of community-based health intervention. *Health Policy and Planning* 2009; 24(5): 335-341. doi:10.1093/heapol/czp028.
5. Urban Health Study Group, Atma Jaya University of Indonesia; Department of Agricultural Education, University of The Philippines at Los Baños; Nutrition Institute of the Federal University of Rio de Janeiro, Brazil
6. International Fund for Agricultural Development (IFAD) (Ethiopia, Kenya, Mali, Uganda, Seychelles, Tchad), United Nations Children's Education Fund (UNICEF), Save the Children Fund (SCF), Medical Mission Action (MEMISA), etc.
7. Greenwood, D. J. & Levin, M., *Introduction to action research: social research for social change*, Thousand Oaks, Calif.: Sage Publications, 1998.
8. De Vos P, De Ceukelaire W, Malaise G, Pérez D, Lefèvre P, Van der Stuyft P. Health through people's empowerment: a rights-based approach to participation. *Health and Human Rights* 2009; 11(1): 23-35.

9. Constitution of the Republic of Cuba (1992). www.cubanet.org/ref/dis/const_92_e.htm.
10. De Vos P. No one left abandoned: Cuba's national health system since the 1959 revolution. *International Journal of Health Services* 2005;35:189–207.
11. Delgado G. Desarrollo histórico de la salud pública en Cuba. *Revista Cubana de Salud Pública* 1998;24(2):110–118.
12. Feinsilver J. M. *Healing the masses: Cuban health politics at home and abroad*. Berkeley, University of California Press, 1993.
13. Reyes-Alvarez I, Sanabria Ramos G, Medina Gondres Z, Baez-Dueñas RM. Metodología para la caracterización de la participación comunitaria en salud. *Revista Cubana de Salud Pública* 1996;22(1):75–84.
14. Ferrer-Ferrer L, Alfonso-Sagué K, Bonet-Gorbea M, et al. Intervenciones comunitarias contra enfermedades crónicas no transmisibles en el consejo popular Dragones. *Revista Cubana de Salud Pública* 2006;32(3). www.imbiomed.com.mx/1/1/articulos.php?method=showDetail&id_articulo=38803&id_seccion=-1250&id_ejemplar=4003&id_revista=79
15. Sanabria Ramos G. Participación social en el campo de la salud. *Revista Cubana de Salud Pública* 2004;30(3). <http://redalyc.uaemex.mx/redalyc/pdf/214/21430305.pdf>.
16. Sosa I. Percepción sobre Análisis de Situación de Salud en un Consejo Popular del municipio Centro Habana en 2008. *Revista Cubana de Higiene y Epidemiología* 2011 in press.
17. Lefèvre P. Acteurs et évaluation de projets de développements. Vers une approche pluraliste de l'évaluation. Universidad Libre de Bruselas 1999 (p.115-117).
18. Guba EG, Lincoln YS. *Fourth Generation Evaluation*. Beverly Hills, Sage Publication 1989.
19. Monnier E. *Evaluations de l'action des pouvoirs publics*. Paris, Economica, 1987.
20. Dilla H, Fernandez A, Castro M. Movimientos barriales en Cuba: Un análisis comparativo. In: Vázquez A, Davalos R (eds). *Participación social: Desarrollo urbano y comunitario: 1er taller de desarrollo urbano y participación*. Havana, Universidad de La Habana. Facultad de filosofía e Historia/Departamento de Sociología, 1996.
21. Dilla H, Fernandez A, Castro M. Movimientos barriales en Cuba: Un análisis comparativo. In: Vázquez A, Davalos R (eds). *Participación social: Desarrollo urbano y comunitario: 1er taller de desarrollo urbano y participación*. Havana, Universidad de La Habana. Facultad de filosofía e Historia/Departamento de Sociología, 1996.
22. Valdes J. Notas sobre Poder Local, movimiento comunitario y democracia en Cuba. In: Davalos R, Basail A. *Desarrollo urbano: Proyectos y experiencias de trabajo*. 2do taller de desarrollo urbano y participación. Havana, Universidad de La Habana, Facultad de filosofía e Historia/Departamento de Sociología, 1997.
23. Rojas-Ochoa F, Lopez-Pardo CM. Economy, politics and health status in Cuba. *International Journal of Health Services* 1997;27:791–807.
24. Serrano P. Cuban democracy does not stop at formal representation. Interview with Ricardo Alarcón, 2004. www.cubanismo.net/teksten_eng/democratic/interview_alarcon_pr.htm.
25. Vazquez A, Davalos R. Comunidad y descentralización: Una reflexión desde los 90. In: Vázquez A, Davalos R (eds). *Participación social: Desarrollo urbano y comunitario: 1er taller de desarrollo urbano y participación*. Havana, Universidad de La Habana, Facultad de filosofía e Historia/Departamento de Sociología, 1996.
26. Centro de Investigaciones Regionales "Dr. Hideyo Noguchi" Universidad Autónoma de Yucatán (UADY México) y el Institute of Tropical Medicine (ITM Bélgica). Estudio de los determinantes sociales de las enfermedades desatendidas y otras enfermedades relacionadas con la pobreza en América Latina y el Caribe. Informe final. OPS/OMS Contrato CS-10-01392. Septiembre 2010.
27. Steunfonds Derde Wereld - INTAL (2010) Reinforcing the capacities of PHM - Latin America for better action towards the right to Health. In: Steunfonds Derde Wereld, INTAL. DGCD-program 2011-2013, Empowerment for the Right to Health. (Part 2, pp.99-112).
28. Jonsson U. An approach to human rights based programming in UNICEF (Eastern and Southern Africa). SCN News 20, July 2000. ACC/SCN, Geneva, and UNICEF ESARO.

