WOMEN IN HEALTH DEVELOPMENT

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WOMEN IN HEALTH DEVELOPMENT

Case Studies of Selected Ethnic Groups in Rural Asia-Pacific

Edited by

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PREFACE

This report examines the process of participatory research in health development involving women. That the virtue of community participation in health care delivery is well known, as is the related fact that women could be the most logical vehicle for such involvement. Less attention has been given to the operational processes in such a development scheme. In many countries of the Asia-Pacific region, female roles have been traditionally subordinate and family centred. Entry into a community oriented, participatory milieu implies not only a modification of their status but also new policy perspectives that have cultural and social dimensions.

The geographic focus of this report is Asia and the Pacific. The region is widely diverse. The countries studied are culturally and physically varied. The six countries selected reflect a wide range of social, cultural, and economic conditions. They share, however, the commonality that they are ethnic minorities (in Asia), isolated and rural. Structural factors responsible for the current situation are likewise considered. It is not only the empowerment of women in health planning and delivery that is important in this study. Rather, the significance of the research lies in the awakening from the latent passivity that mobilized the women toward an increased consciousness of their health problems, the planning for the selected schemes, and the implementation cum evaluation of the planned programme. The problems associated with linkages with the community leaders, the menfolk, relevant government agencies, and private organizations which are considered processes of adjustment and accommodation are elucidated. The focus on participatory research in health development gives one a perspective of a wide range of issues related to community involvement in development. The major question is: why should the women be focused upon in participatory research in health development? There are at least four reasons for this tendency:

First, the mothers have the major task for the health care of their families. Therefore, the effective implementation of the community participation concept of primary health care implies their involvement at all levels of planning and management.

Second, traditionally, women are the managers of local resources such that their active takeover of health services in the community will not detract largely from their normal activities.

Third, relegating women to mere passive recipients of health services underutilizes human resources and stunts their development process.

And fourth, the elevation of the status of women and recognition of their human rights and dignity demand great improvements in their health conditions, access to health resources, and participation in decision making at all levels.

This report is organized into eight chapters. Chapter I provides the empirical and conceptual overview of participatory research in health development process as well as the background of the research. In Chapters II–VII, the experiences of the six countries are reviewed. Each country's implementation procedure from the researcher's entry into the community until the programme evaluation is analysed and the lessons emanating thereof are discussed. Despite guide-lines provided, deviations exist due to the realities of the community situation.

The last chapter consolidates the six case studies, derives generalization from the preceding chapters, and discusses the operational guide-lines in replicating the study.

Chapter I provides the philosophical perspective of participatory research with particular emphasis on health development. It serves the useful purpose of providing the broad context within which the research project is viewed. It likewise presents previous studies related to participatory research and the methodology. In previous studies, three elements were pervasive in the perception of the participatory approach: popular participation in the extrication of community problems, utilization of indigenous and culturally appropriate methods, and adoption of grassroots mechanism in which action is taken to validate solutions.

Chapters II–VII consist of the six country case studies: Malaysia, Thailand, Philippines, Fiji, Papua New Guinea, and Vanuatu. In the succeeding paragraphs, highlights from the country reports are selected.

The Berawans of Sarawak, Malaysia, have had exposure in community health through the village promoters. Following systematic stages, training in problem formulation was provided through creation of plasticine models of ill persons, informal dialogue sessions, and a community survey. Strategies were selected through discussions which covered the task specification, man-

power needs, and organization of the community. The participatory approach adopted in programme planning assisted in building confidence and developing leadership qualities in the women.

Among the Yaos of Thailand, it was revealed that a health awareness and leadership training programme was a precondition to an effective participatory approach to health development. Sufficient time was allocated for the internalization and diffusion of the health concepts prior to the mobilization of the women for the problem prioritization and the planning of the health programmes.

The major challenge for the researcher in the Philippines was the transformation of the Mangyans from their inherent reticent nature and dole-out mentality to active involvement in taking the initiative in defining their health needs and making representations to government and private agencies for assistance in their health programme. The procedure involved the rectification of certain misconceptions regarding their situation and strengthening the linkages with relevant agencies.

In the Pacific, active women's organization as well as government agencies became the media for the participation of women in health development. In Fiji, while it was demonstrated to the women that they can be actively involved in activities that have concrete results – the smokeless stoves and communal laundry facilities – the major thrust of the research was the provision of basic knowledge and skills for problem identification and solution formulation relative to their situation. Focus was placed on the preparation of simple health programme designs.

In Papua New Guinea, leadership emerged as a very important factor in the involvement of the women in problem and programme delineation. An active woman leader set the pace of the tasks and by bringing the men into the programme, funds were generated to install water tanks. Income generation was considered an important prerequisite to health programme sustainability.

In Vanuatu, it was perceived that the parallel involvement of relevant government development agencies and the local leadership could enhance the participation of women in health activities. The training programme attempted to balance skills in problem formulation and the implementation of relevant programmes.

The projects were carried out in the rural milieu of the women with inherent problems emanating from resource constraints, the attitude of the community, the time allocation of women, village conflicts, the researchers' dilemma, the community work pace, and catastrophes. At the end of the project period (thirty-six months), the projects were at different stages of completion. For some, more time was allocated to the imparting of skills in health problem definition, consensus building, and planning. The others

embarked on easily demonstrable tasks to show the women that with communal deliberation and action, they could meet their health needs. The approaches varied to suit the local conditions.

Chapter VIII, the concluding chapter, extricates the integrative themes from the case studies and offers suggestions to address the issues of sustainability and self-reliance. The themes involve the assessment of the major areas in the involvement of women in the programme planning and implementation, such as ways by which the physical and external resources of the community could be drawn out, the data needs for the delineation of health problems, entry points, the local documentation perspective, the positive and negative factors in objective attainment, sustainability, and self-reliance. Towards the end, guide-lines for the implementation of participatory research in health development were suggested. Finally, unresolved problems in participatory research were raised, such as the concept of participation, the selection of the participatory medium, the community's role, and incentives.

While the challenges of participatory research in health development are immense, these should serve as a trail-blazer to researchers who wish to undertake truly significant work in health. The operational processes in this report do provide information sufficient to conclude that women can have dual tasks — the responsibility for the health care of their families and contribution towards the formulation and solution of health problems at the macro community level. It is too early to determine the long-term implications of the project but in the long run, it is hoped that the active involvement of the women in the development of health in their communities will be considered at the policy level.

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Development is increasingly seen as an awakening at the "bottom", i.e., a catalytic process of freeing the creative forces of the impoverished and exploited of any given society and enabling those forces to come to grips with the problems of underdevelopment – Hall[1]