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APPENDIX
METHODOLOGY OF THE RESEARCH

The approach in this research was documentary and qualitative. This methodology is intermediate between posited theory and empirical analysis. Rather than systematically inferring a range of hypotheses from preconceived theory specific to classical research and validating them, the process of evolving issue from the observed phenomena was invoked. Analysis proceeded in a sequential fashion from the first stage of community organization to the last phase of programme evolution. The observation approach preceded the formulation of theories and propositions but, at the same time, was guided by a set of theories and concepts of participation.

Essentially, the approach utilized was a grassroots, bottom-up one, as contrasted to the more common elitist top-down approach found in much of the literature on health delivery. The major aim is to explore the conceptual frame of the women in the realm of health – an element which permits the interpretation of health situation in the light of the meanings which these women attribute to their health-seeking behaviour, which subsequently enables the researcher to understand the cultural bases of communal action formulation. The women's cultural milieu, their standing in society, and their conceptual knowledge can pose a major challenge to the formulation of self-reliant health programmes. To implement the programme for women's involvement in health care, the methods employed were largely discussions and observations, together with the documentary analysis.

The research was conducted at two levels: that of the researcher and the community with an interface in most aspects. In this participatory action research, several steps were envisioned with the researcher and the community being involved in similar and, sometimes, complementary tasks. The major

tasks of the researcher were the documentation of all aspects of the community's activities, extraction of important issues relevant to the assessment of women's capability to carry out the various steps in setting up a simple health programme, and evaluating the programme designed and implemented by the women in terms of processes and their sustainability. The steps taken were:

1. Initiation of Contacts with the Community – The researcher undertook the participant observation technique and key informants interview to gather village data on the population, physical surroundings, and health resources. With the assistance of selected community members, census data were collected. Besides, leadership patterns were established. In initiating contacts with the community, the researcher met with political leaders, government agencies, voluntary organizations mainly run by women, community leaders, and mothers to discuss health issues and possible ways of meeting the health needs by the community. A task force was convened to identify the women who were eventually trained for data collection. A training period was set aside for data collection, followed by field-work.

2. Extraction of Problem Issues – This stage involved a number of techniques, such as group processing of data collected in the survey and focused group discussions, followed by a series of dialogue sessions in which the women's perceptions of the health problems, the resources available in the community, and possible strategies for meeting specific health needs were discussed. The researcher facilitated the discussions, drew out the important issues, and encouraged the women to posit viable solutions. The women were made aware of how important their potential contribution was in bringing about health changes in their own community.

   The data collected earlier were presented in culturally relevant forms in these dialogue sessions for needs assessment as well as prioritization of issues. The analysis combined survey data results, focused group discussions, key informants interview, and a historical review of previous development programmes.

   During these dialogue sessions, an inventory of resources and manpower capability related to the health needs prioritized by the women was undertaken to evolve a reasonably feasible strategy. Besides, external resources that could be tapped were properly identified. Securing commitment to the health programme was done through the discussion of easily implemented health tasks, e.g., environmental sanitation campaign, family planning information, and drug management.

In the course of this process, the researcher took note in the dialogue sessions of the following:

(a) Decision process – what and how the objectives were set;
(b) Prioritization of health issues – approaches utilized and conclusions that emerged;
(c) Strategy selection – basis of programme formulation, resource inventory, mechanism of programme formulation; and
(d) Proceedings of discussions, problem areas and resolutions.

3. Formulation of Strategy – During the dialogue sessions and meetings with the key women leaders or committee, a strategy was selected that was based on the problems defined earlier, the consensus of the group, and the resources available (material and manpower). The mechanism for the implementation of the strategy selected was spelled out in terms of the operational (process) objectives and the outcomes expected. The financial requirements and the perceived sources were delineated and the base of the strategies determined (existing organizational set-up or new structure).

In all these deliberations, a woman selected by the group documented all the proceedings while the researcher acted as the community organizer, facilitator, and synthesizer who highlighted specific issues and fed these back to the group either for reinforcement, action, suggestions, or further discussion.

In formulating the strategy, the following considerations were taken:

(a) Performance objectives – health education campaign, supplementary feeding;
(b) Target households/location of programme base and satellite points;
(c) Material requirements (booklets with pictures, herbal drugs, etc.), financial implications of tasks, and possible financial sources (contributions, income-generating activities, etc.);
(d) Recruitment of programme staff – volunteers, selected by committee;
(e) Requisites for workers' selection – literacy, marital status, leadership, previous involvement in health activities;
(f) Training requirements – depending on selected strategy;
(g) Activities and tasks – catchment areas in terms of households, motivation, education, managing drug store, record keeping; and
(h) Nature of community involvement.

4. Training of Health Workers – Upon recruitment of the health workers for a specific strategy or activity, the training needs were identified and the appropriate agency (health centre or non-governmental agency, e.g., religious mission) was tapped by both the researcher and the selected women in the community. The training was geared toward the basic

strategy selected as well as the capability of the staff. It took into consideration the following:

(a) Content – congruent to the objectives set, relevant to the problems identified, adapted to local needs and circumstances, involvement of women in the design of the content of the materials;
(b) Methods – lecture, demonstration, visual aids, role playing;
(c) Manuals and materials – prepared by the selected women under the supervision of the health staff, which included pictures, diagrams, and kits. The language was local;
(d) Location – a house or a centre in the community: school, church site, etc.;
(e) Trainers – health centre staff, community health workers, women leaders;
(f) Duration and schedule – daily, weekly, specific hours during the day (on the dates the women were available);
(g) Class size;
(h) Evaluation of training – observation, pre- and post-test, group discussion of what was learnt; and
(i) Provision of refresher training.

5. Project Implementation – Catchment areas were assigned to women who selected their assistants. A referral system was set up and a board composed of local leaders was convened to assess progress made, discuss problems in project implementation, share experiences, and modify the programmes. The frequency of the meetings of this board was decided based on the availability of the members.

Specific programme guide-lines were adopted and adjusted to the existing structure of the village which reflected the inherent authoritative position of the formal and informal leadership and the available time that the women had for non-domestic activities so as to enable them to participate in the proposed health project. A major consideration in getting the women to participate in this research was to adapt to their household responsibilities so as not to detract from their traditional roles.

In documenting the operational processes, attention was given to the following:

(a) Activities and tasks of the personnel;
(b) Work schedule of staff;
(c) Programme sites;
(d) Programme details;
(e) Mechanism for programme sustenance;
(f) Response of beneficiaries;
(g) Administrative framework for the projects;

(h) Duration of implementation;
(i) Referrals, if any; and
(j) Nature of meetings.

6. Supervision and Support – Supervision and support were given by the health centre staff and local women leaders if they had the capability to do so. Considerations were given to the following:
   (a) Nature and frequency of supervision; and
   (b) Support network.

7. Monitoring and Evaluation – The women in the community kept simple records which were assessed regularly by the committee and the researcher to determine progress, gaps in programme implementation, and modifications, if necessary.

   In assessing the outcome of this women's participation project, the long-term objectives of health improvement may not be realized in the project span. What is important is the more sustainable effect on the strengthening of the women's capability to define the problems and plan a viable health programme: the inculcation of the feeling of confidence in obtaining a clearer understanding of their health problems, the capability to address these problems in a pragmatic sense, and the ability to discuss the programmes and modify them accordingly. What is important is the recognition of the health problem and the ability to convene and discuss the issues, posit alternative solutions, and arrive at a communal plan of action.

   Monitoring and performance evaluation issues included the following:
   (a) Areas of evaluation – the programme, extent of community participation or support, attainment of short-term goals, women's capability to manage the programme;
   (b) Frequency of monitoring;
   (c) Nature of monitoring – meetings, documentor's reports, observation of staff;
   (d) Evaluators – women leaders, members, external evaluators (health agency staff and researchers); and
   (e) Methods – reports, focused group discussions, key informants interviews, participant observations, case studies.

Documentation

The research process was documented at two levels:

1. by a representative selected by the community; and
2. by the researcher.

Toward the end, the researcher synthesized the community documentor's reports.

Community Report

A woman from the community was designated as rapporteur who recorded all assembly proceedings, daily activities, and other events in the community. Diaries were kept and summaries were written on all aspects (steps) of the project. These were synthesized under the supervision of the researcher. The records were written in the local language in narrative form. They include the following information:

1. Background of the community, geographical location of the village, socio-economic description, and power structure, including the position of women.
2. Initiation of the group activity – when the activity was initiated, who took the initiative, conditions in the village giving rise to the activity, how plans were formulated, resources mobilized, organizational structure set-up.
3. Activities – description, objectives, implementation scheme, allocation of tasks, problems in implementation, modification.
4. Membership – nature of leadership, activities and tasks of members, functions of leadership and members.
5. Organization – structure and functions of the project.
6. Support services – linkage with agencies within and outside the community.
7. Problems encountered and solutions developed.
8. Evaluation of programme performance and outputs.
9. Lessons learned from the project.

This community report was translated and supplemented by the researcher's report. Both were discussed and presented during the group meetings.

Researcher's Report

Using the ethnographic research approach, the researcher documented all activities undertaken in the community, from the initiation of community contact to evaluation. As facilitator, the researcher provided diagnostic feedback to the community and the women regarding the operational processes and problems to extract key issues emanating from the discussions. Some areas that were focused were the operational processes, task delineation, resource mobilization, and evaluation. Another approach was participant observation drawn from the key activities carried out in the community which were reported

with varying degrees of interpretation. Likewise, key informants interview was utilized, using an open-ended or unstructured questionnaire.

Cross-Cultural Linkages

From the participating countries' reports, comparisons were made on the mechanism for problem identification and the cultural content in the processes involved in solution development and validation. Specific cultural elements that served to facilitate or constrain the implementation of the projects were identified. The issues encountered in planning and implementing the health projects were extracted and the potentials for replication in similar cultures were explored after defining the processes by which participatory action could be maximized.

As outlined diagrammatically in Figures 7 and 8, the project consisted mainly of four phases:

1. the basic information procurement and assessment phase;
2. the programme planning stage;
3. programme implementation and evaluation; and
4. evaluation of the participatory mechanism.

Given the participatory nature of the process, greater community input was drawn in all the stages with the researcher acting as a catalyst, facilitator, or community organizer in each process as well as a documentor or supervisor in the documentation of the process. With regular feedback to the women members regarding their implementation process, necessary changes or improvements were instituted as they went through the various research stages.

FIGURE 7
Outline of Phases, Processes, Documentation, Site Visits and Workshops of Participatory Project in Health

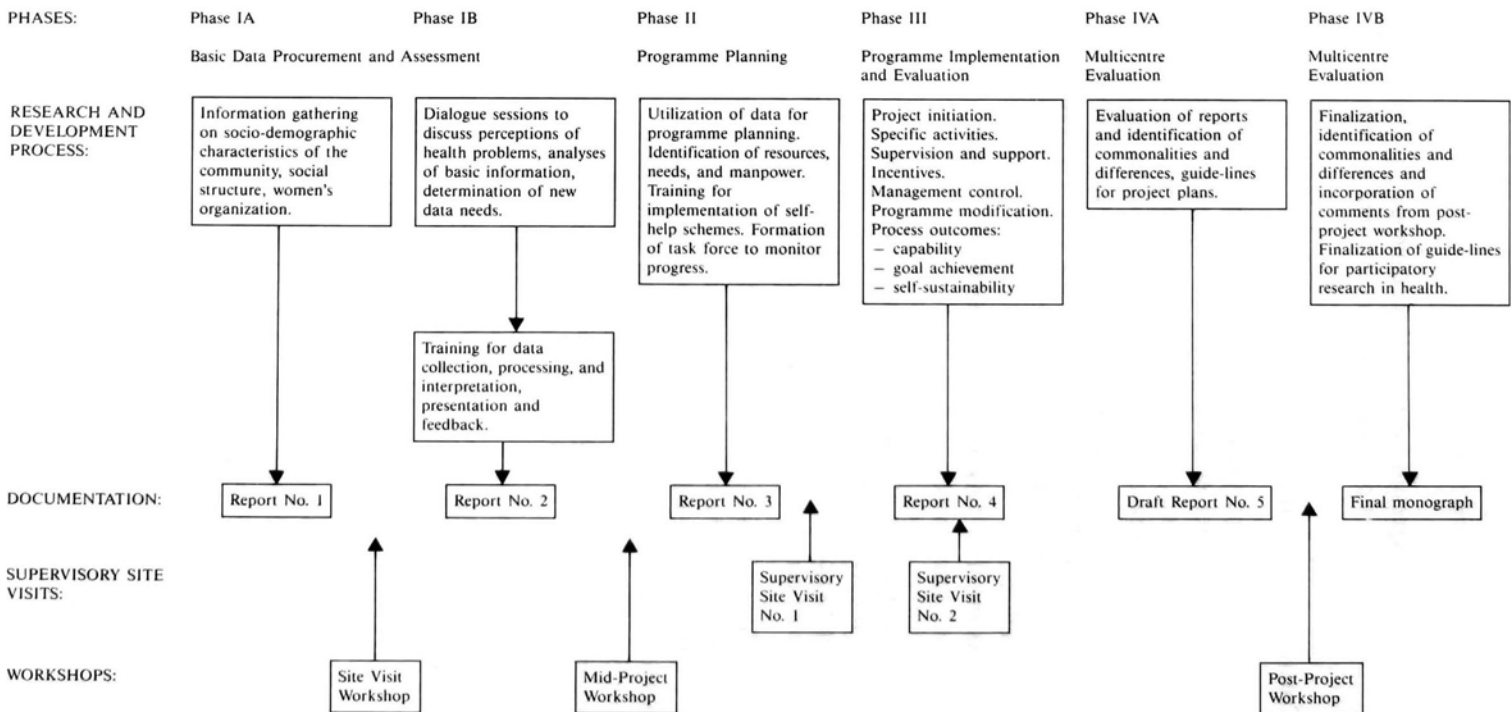
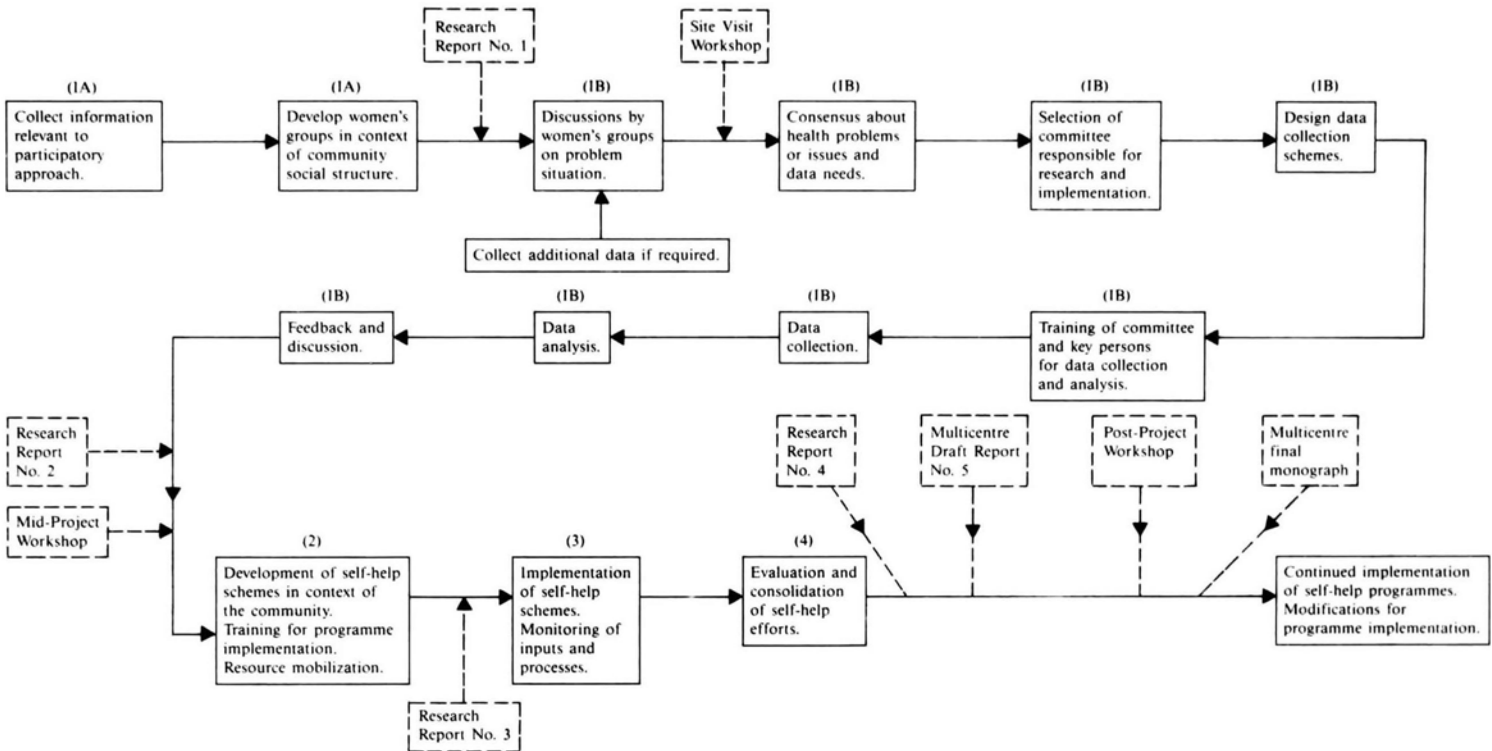


FIGURE 8
Steps in Participatory Research in Health



NOTE: Phases are indicated in parenthesis.