

Research Article

# Learning with Communities: Structures and Mechanisms for Reproductive Health Programs among Indigenous Peoples of the Cordilleras



Erlinda Castro-Palaganas, PhD, RN<sup>1</sup>



Ma. Visitacion Perez-Molintas

## Abstract

This paper attempts to capture how the principles of Participatory Action Research (PAR) were put into life in the integrated reproductive health (RH) programme in the Cordilleras, Northern Philippines. Document Review and interviews of program staff were utilized to learn from the field and data were derived from participatory methods such as Group and Team Dynamic Methods, Interviewing and Dialogue Methods, Sampling Methods, and Visualization and Diagramming Methods. Results show that Community



Needs Assessment, (CNA) as a baseline for integrated planning of programme partners, laid a PAR framework for the entire development process. With the guidance of the integrated RH framework, the CNA ensured relevant and correct interpretation and analysis of data which then led to meaningful plans, actions and partnership, having gained the acceptance of communities. Community structures – People's Organizations with Health Committees that oversee income generating projects and RH education activities in the *barangays* (villages)<sup>2</sup>, were strengthened; partnerships with the *Barangay* Councils (BC) and the *Barangay* Health Stations (BHS) are continually enhanced to make policy formulation and service delivery more responsive to RH needs. Through this, the community was presented as a powerful unit of identity that builds on the strengths and resources of the community. The experience revealed that co-learning and capacity building can be promoted, and knowledge generation and intervention is integrated. The experience also emphasized the local relevance of public health problems (RH in this case) and the multiple determinants of health and disease including biomedical, social, economic, and physical environmental factors. To the researchers, it has been an inspiring and empowering experience to grow and learn with the people.

**Key words:** *Participatory action research, reproductive health, gender, population development, training/community education, advocacy, networking*

## Introduction

Participatory action research (PAR) has long been recognized as a methodology for intervention, development and change within communities. This claim has been supported by the work of many

international development agencies, university programs and local community organizations around the world. Lewin wrote about 'action research' as early as 1946 in his paper "Action Research and Minority Problems" while

<sup>1</sup> Corresponding Author: Institute of Management, University of the Philippines Baguio, Governor pack Road, Baguio City; [ecpalaganas@upb.edu.ph](mailto:ecpalaganas@upb.edu.ph); +63 74 4425703

<sup>2</sup> *Barangay* is the local term for village, the smallest administrative unit in the Philippines.

Susman's work on Action Research: A socio-technical systems perspective was published in 1983. PAR has been used extensively in the social sciences after these seminal works.

More recently, Wadsworth (1998) defined PAR as research that involves all relevant parties in examining problematic action through reflection on historical, political, cultural, economic, geographic and other contexts. In bolder terms, Mustafa describes PAR as it "involves the political participation of the oppressed and exploited classes in conducting research on the causes of their exploitation (in Carlos and Santos, 1993)." It is because of these characteristics that PAR separates from other types of research. O'Brien (1998) aptly explains, PAR is "learning by doing" where a group of people may identify a problem, do something to resolve it, observe how the results of their efforts, and if not satisfied, repeat the process. PAR also strongly emphasizes scientific study where researchers not only study the problem but ensure that theoretical considerations are guided by scientific study.

PAR, as a framework, has been modified many times. One variation of which is action research, which validates academically-formulated theories through the people. Another variant, labelled as participatory research, raises awareness by objectifying their situation and by closely looking at the data and information collected. In particular, this paper focuses on PAR's principles and how these were pursued in learning experience for the promotion of reproductive health (RH).

## Background

In 1978, the World Health Organization (WHO) adopted Primary Health Care as an approach in achieving its goal of Health for All by the year 2000. This goal was later updated to be included in the eight (8) Millennium Development Goals; the fifth of which pertained to RH. Despite all the global and local initiatives, the goal of "health for all" is still a challenge. The rural poor remain to have less access because of the concentration of resources in the urban areas. The lack of financial resources, limited knowledge of health matters, and limited access and use of health services have handicapped the disadvantaged. Part of the efforts at alleviating health standards is the development of poverty-oriented reproductive health goals for monitoring progress in the health of the poor.

The UNFPA 6th Country Programme of Assistance for the Philippines (CPAP) aims to improve the reproductive health of Filipinos through better population management and sustainable human development and is guided by the principles of the International Conference on Population and Development's (ICPD) and its mission of assisting developing countries in addressing reproductive health by ensuring universal access to high-quality RH services by 2015. A country review in the Philippines was conducted to improve the efficiency and strategic direction of the UNFPA reproductive health programmes. The country review yielded several recommendations for the Department of Health, including: (1) to take charge of the RH programme and develop an operational strategy, a phased implementation plan, and organizational structure and a realistic budget and; (2) take the lead in preparing its 10-year investment plan and coordinating donor investment to support the projects on reproductive health (UNFPA, 1999).

The UNFPA 6th CPAP directed its resources to ten pilot provinces prioritized according to key poverty and reproductive health indicators, such as: population size; maternal mortality rate (MMR); infant mortality rate (IMR); contraceptive prevalence rate (CPR); proportion of moderately and severely malnourished children; percent of births attended by skilled workers; income class; poverty index; high school drop-out rate; and high school survival rate. Aside from the fact that it was one of the 10 poorest provinces in the country, Mountain Province<sup>3</sup> was identified most in need of an integrated reproductive health programme based on the following baseline RH situation in 2005:

1. Sustained and thorough-going IEC seemed to be lacking as manifested by the decreasing coverage of pre-natal and post-partum services and the differentials in FP performance across municipalities.
2. There was no mechanism for the pro-active detection of emerging health issues like sexually transmitted diseases (STDs).
3. Majority of the barangays (villages) in Bontoc and Sagada did not have their own Barangay Health Station (BHS), while those in Paracelis were either in deteriorating condition or geographically inaccessible to other sitios or parts of the village.
4. There was no program related to adolescent sexuality and RH or life-skills building, whether in school or the communities.

<sup>3</sup> Mountain Province is among the six provinces of the Cordillera Administrative Region (CAR), a region located in the northern part of the Philippines.

5. Violence Against Women (VAW) was admittedly a growing concern but data was lacking to establish the extent of the problem. IEC on VAW was lacking. There was no clear policy on VAW nor was there a clear referral system for handling VAW cases.

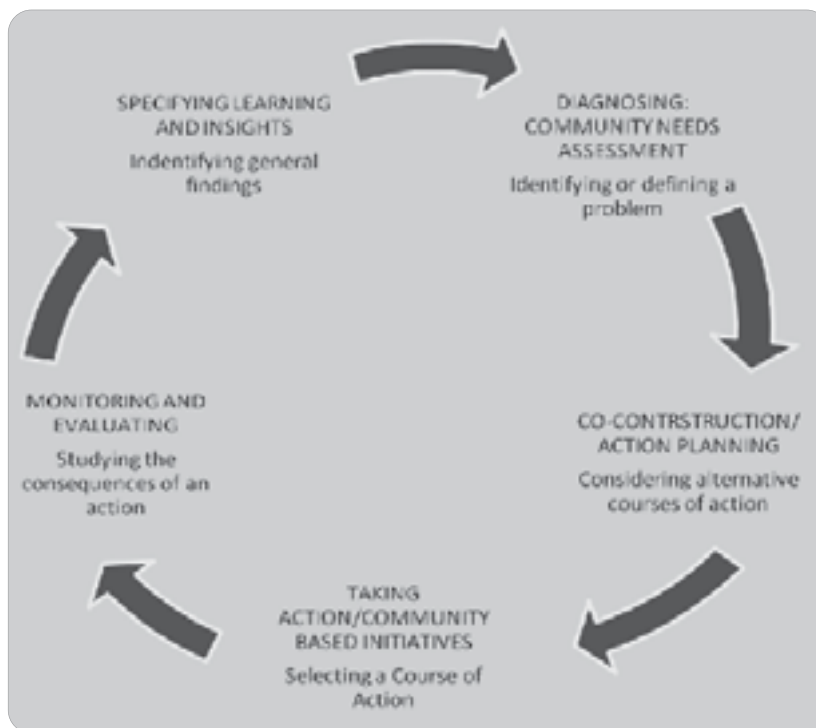
In response, strategic interventions were developed along three major components -- population development, reproductive health and gender. Congruent to primary health care's principle of community participation, PAR has been deemed appropriate for the development of integrated RH programmes specifically in the Cordilleras. This approach involves the people in the process of decision-making, planning, and project implementation to solve their community problems or issues.

### Conceptual Framework

PAR is a continuous process which starts with the identification of major issues, concerns and problems and the initiation of research. This research, in turn, is expected to originate action, from which lessons may be learned and new research questions raised. Participants continuously reflect and proceed to initiate new actions on the spot. Outcomes are difficult to predict, challenges are sizeable and achievements depend, to a very large extent, on the researchers' commitment, creativity and imagination. Gerald Susman (1983) distinguishes five phases to be conducted within each research cycle and action (Figure 1).

Initially, a problem would be identified and data collected, followed by a collective postulation of several possible solutions, leading to a single plan of action to be implemented. Data are collected and analyzed, findings are interpreted and the problem is re-assessed, leading to another cycle of the process. This process continues until the problem is resolved. Learning and insights were derived in all these phases using triangulation of methods.

**Figure 1:** Adapted from Gerald Susman (1983)<sup>4</sup>: Five phases of the PAR cycle



### Study Context and Methods

More than 4 years of implementing PAR with LGUs and pilot/expansion communities in the Mountain Province enabled the integrated RH programme to lodge complementing structures and mechanisms in achieving program goals and outcomes towards improving the RH of indigenous peoples in this part of northern Philippines.

The Philippine Health Social Science Association in the Cordillera Administrative Region (PHSSA-CAR)<sup>5</sup> has worked as the local NGO partner for RH demand-generation under the UNFPA's 6<sup>th</sup> CPAP. It has stood as the catalyst for generating, disseminating and applying knowledge generated from the Community Needs Assessment (CNA) conducted in Mountain Province. It linked the LGUs to the communities in raising awareness about the needs at the

<sup>4</sup> Gerald I. Susman is credited with establishing Action Research in his seminal work: *Action Research: A socio-technical systems perspective*, edited by G. Morgan and published in 1983 by Sage Publications.

<sup>5</sup> PHSSA-CAR is a non-government organization guided by a vision of persons, groups, and communities coming from different work settings, experiences, backgrounds and disciplines, working together as partners, sharing their knowledge, expertise and resources in promoting the health of the people through empowering strategies. PHSSA-CAR is also committed to the development of health social science as an integrated domain of effective, accessible and responsive health policies, programs, and services.

grassroots. In turn, the communities were able to demand for and assert their RH needs. While the LGUs were continuously being strengthened to provide RH information and services (supply), PHSSA-CAR focused on generating quality RH information and services. Thus, effective mechanisms were developed and access and utilization of RH information and services were also increased.

PHSSA-CAR worked in 25 project *barangays* in the Mountain Province from 2005 to 2009, starting with 10 pilot *barangays* in 3 municipalities and later in 2008, included 13 expansion *barangays*. The four-year experience of PHSSA-CAR in PAR and project implementation under the UNFPA 6<sup>th</sup> CPAP is summed up as: community needs assessment and objective setting; project development and start-up activities; implementation of community-based initiated (CBI) projects; group enhancement activities and municipal-level federation building of people's organizations (POs); group sustaining activities and beneficiary expansion of CBI projects; expansion of CBI projects and support network for RH; and monitoring and evaluation (M & E).

The experience enabled program partners and other players to gather valuable lessons as the researchers strove to collate the results and learning presented here in the context of the PAR process and the different phases in implementing the integrated RH program in the Mountain Province. Review of documents provided a wealth of secondary data and interviews of program staff, communities and partners drew out insights and infused life to the stories of learning from the field.

As per the recommendations made by Huberman and Miles (1994), data collection and data analysis were combined into an interactive process. The analysis phase included all the stakeholders and sources of information. Interpretations and explanations were offered and the participants in the study were the members of the community themselves. Also, by conducting analysis as a joint activity, the team brought its perspectives forth into the discussion, as an opportunity for dialogue and debate about the findings.

### **Ethical Considerations**

As researchers, we dealt with several ethical issues. Several methods were used to ensure utmost integrity protecting the rights of the participants. Free prior informed consent was solicited. Even as partners in the

community, full disclosure was given on what study/project was about. The research concept and framework was presented and received approval from the officials at the provincial, municipal and *barangay* level. Through community assemblies at the *barangay* levels, the research concept was presented. We disclosed the end users or stakeholders with access to study results/data; funding; methods used and the specific roles of the participants. The nature of PAR required the participation of the people in the communities in all the phases of the project. The process of organizing complementing structures and mechanisms in achieving program goals and outcomes towards improving the RH of indigenous peoples in this part of northern Philippines was documented, analyzed and validated through a feedback session in the communities. Actions/activities were analyzed with the players which brought perspectives to discussion and an opportunity for dialogue and debate about the findings. These enhanced the trustworthiness of the data as they become springboard for the next action/s or step/s.

### **Findings**

The following sections present the various facets of learning with the communities as we journeyed with them in forming structures and mechanisms for RH Programs. Data presentation follows the five phases of the PAR process adapted from Susman (1983).

#### ***Diagnosing: Community Needs Assessment***

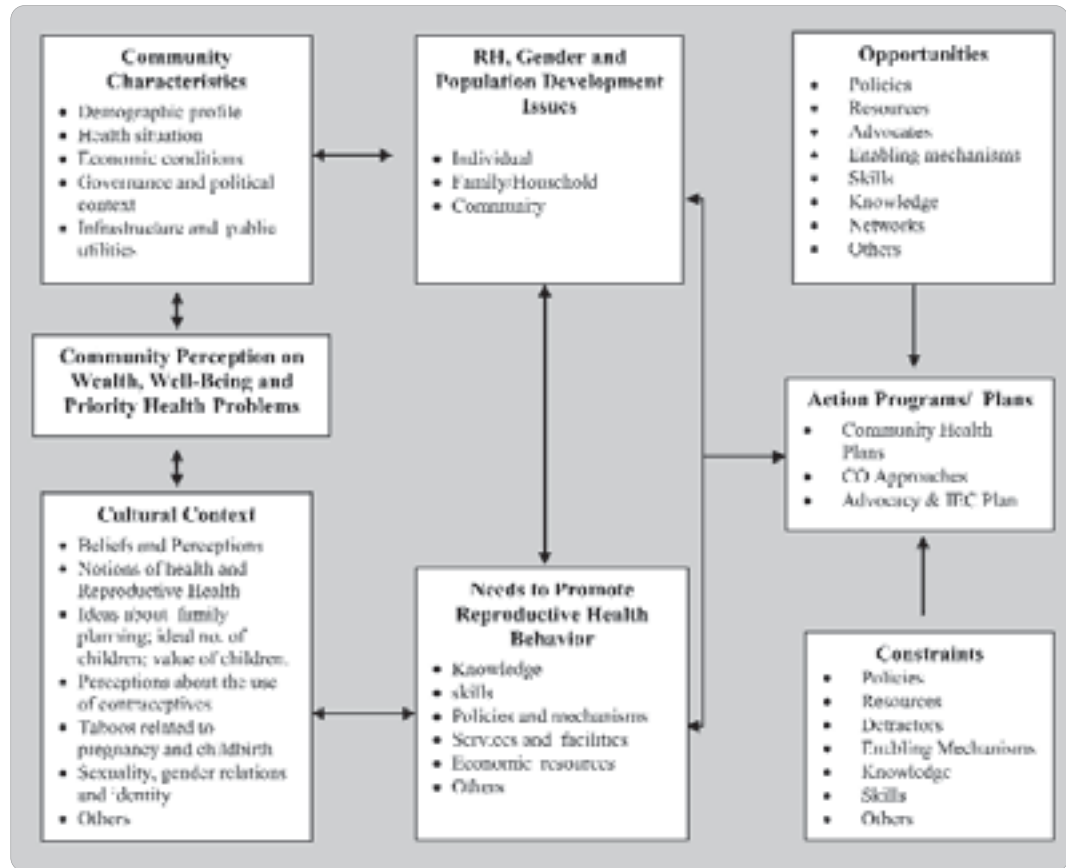
Community Needs Assessment (CNA) was the first phase in the implementation of the integrated RH programme in the Mountain Province. PHSSA-CAR, through its community organizers (Cos), facilitated the CNA in late 2005 in the pilot municipalities and took 10 months to complete the entire process of data collection, analysis, and report writing.

The CNA gathered baseline data to assess the RH needs and provided information from which future plans and interventions were based. Among others, the CNA described the health situation and summarized key problems and possible solutions. Sexual and reproductive health issues and related concerns were articulated which led them to analyze and reflect on their family and community conditions, problems and needs that are inter-linked to health and well-being, thus enabling them to have an integrated perspective of RH.



Figure 2. Analytical Framework for the Community Needs Assessment

The CNA as designed by Sobritchea (2006, Fig. 2) and aimed to: generate qualitative information on prevailing beliefs, values and norms on health, sexuality, gender and local governance issues; provide a political, social, economic and cultural context of reproductive health problems; identify the needs of the community by sex, age, and civil status; determine proposed actions for resolving problems by various stakeholders, and develop a community vision for health. Its framework called for the generation of 7 data sets from the following research methods: 1) wealth ranking and mapping; 2) free-listing of problems; 3) focus group discussions (FGDs); 4) case studies; 5) key informant interviews; and 6) secondary data gathering.



Correct identification and analysis of RH-related problems and concerns through the CNA led to RH interventions that were identified in the planning sessions with the communities. By assessing the state of RH-related programs and services at the community-level, and the prevailing perceptions on well-being and health in the community, the CNA created an initial demand for integrated, responsive, high quality and sustained RH information and services, especially for youth and adolescents, mothers and children. The findings helped identify the essential elements by which to respond (supply side) to the needs and concerns of the communities (demand side). The identified gaps in RH information and services determined the output indicators towards increased community awareness, and stronger community mechanisms and structures for integrated health planning, advocacy, resource-sourcing and service delivery.

**Co-construction/Action Planning: Considering alternate courses of action**

The list of responses to problems in the CNA served as the basis of the action plans and proposals for community-initiated projects. Results showed that the lack of income opportunities ranked high in all the pilot sites and it came up persistently alongside problems like maternal and reproductive health, violence against women, and the lack of water and the presence of external threats. The findings, interpretations and conclusions were presented to the community members, for the following purposes: 1) for comments and suggestions; and 2) to draw out specific proposals, plans, and recommendations for the formulation of a people-based, gender and culturally-sensitive and people-managed action plans dependent on identified needs, issues, and aspirations.

The co-construction of the RH programme followed. It focused on strengthening peoples' organizations (POs) and setting-up income-generating projects (IGPs) that

incorporate RH services. Working meetings were organized to develop a program to promote their own well-being as co-clients of the municipal and provincial health care setting. The discussions involved the creation of health committees of POs, the raising of counterpart funds for the POs' start-up capital, the creation of organizational savings for health and reproductive health emergencies, the generation of health and RH funds to augment the existing budget for essential drugs and family planning (FP) supplies, individual or household savings for RH, and the conduct of RH and gender information, education and advocacy. This approach involved stakeholders as principal players in the process of co-construction of programs aimed at meeting their needs (Guba & Lincoln, 1989), in accordance with the principles of participatory action research (Henderson, 1995).

#### ***Taking Action/Community-based Initiatives: selecting a course of action***

Community Organizing (CO) was utilized in the planning and implementation of RH. It was also used in the organization and strengthening of core of organizations working for reproductive health and rights in the three municipalities; and strengthened coordination between community RH networks for an integrated CNA-based health development. Planning and implementation were identified as output indicators for the component of capability building.

The communities were strengthened with knowledge and encouraged to assert the utilization of high quality RH information and services. Officers and project teams worked for extended hours of discussion and paperwork to complete all other requirements in the criteria checklist for CBI projects. Such requirements included Constitution and By-Laws, minutes of meetings, election of officers, policies on how to utilize earnings from CBI, Memorandum of Agreement for the CBI projects, and opening of bank accounts of recipient organizations.

PHSSA-CAR, with the assistance of different POs, drew up, discussed and explained basic guidelines and terms on the use of the CBI funds. The guidelines and policies developed by the POs were finalized together with the LGU partners. Before project approval and release of funds, the project proposals were presented to program partners at the municipal level for validation. Community assemblies and project orientation of POs were likewise required for review of guidelines before fund release and project implementation. Awarding of funds for CBIs was guided

with conditions and agreements stipulated in the Memorandum of Agreement signed by the local partners involved.

Following the release of funds, start-up activities were conducted for managing community projects and resource mobilization for RH. Project management policies and structures, implementation and budget plans were further reviewed. Moreover, project-based training was conducted to provide hands-on knowledge on their CBI projects, credit management and savings mobilization, project M & E.

The latter phase of the CBIs involved deepening of RH awareness and organizational capacity of POs to manage the projects and sustain RH outcomes. At this stage, the POs were strengthened to conduct planning and networking for generating local and external resources for community initiatives and participatory resolution of priority RH problems.

#### ***Monitoring and Evaluating: studying the consequences of an action***

Evaluation in the action research process took place throughout the study and during evaluation, as both stages were assessed. Questions were asked and reflected on, such as: Are we using the correct instruments? Are we getting the data we need? Who else do we need to interview? Is the process working? These questions kept the focus of the project. In the process, the main facilitating and constraining factors affecting implementation and the achievement of results were derived.

This phase was a reflective critique of the content of the co-constructed RH programme. Both quantitative and qualitative methods of evaluation were utilized but qualitative evaluation methods such as on-going/built-in evaluation; process documentation on program implementation, involvement of stakeholders in the implementation of the programme, strengths and constraints in program implementation, sustainability and replicability of the programme were given more weight for this study.

#### ***Specifying Learning and Insights: Identifying general findings***

The quality of research output was achieved for baseline study on which future integrated programme

interventions in the different components were based. This was attributed to the following factors such as: a clear and integrated framework for analysis and methodology that provided an overview of the information needed (thru the data sets) and how these are interrelated; the CNA tools (FGD/KII guides) are exhaustive but identify the most significant information for more focus and probing, given the time constraint for the discussions; technical assistance of consultants whose expertise were sought for the CNA reports; research staff with research training and experience, and dedication to the completion of the task regardless of continuous and rigorous fieldwork; the reliability and validity of data was ensured with the hands-on involvement of the staff in the CA process, closely working with the consultant/s in doing write-ups and editing; staff workshops with the consultants; and field demonstration of FGDs/KIIs in the first *barangay* and team reflexivity sessions that helped improve the facilitation skills of COs and the process of FGDs.

Factors that facilitated continuing community education and behavior change communication (BCC) for RH led to the formulation and implementation of responsive policies and services for integrated RH. The CO approach was vital for utilizing the CNA results and PO meetings as continuing activities for BCC and policy advocacy at the *barangay* level, and networking for implementing the integrated RH programme at the municipal and provincial levels. The CA activities spurred interest on issues related to adolescent sexual and reproductive health (ASRH), and led to community education sessions of POs that integrated RH issues especially for out-of-school youth (OSY). LGU partners consciously integrated services for young people, although these were made under the provision of information for awareness-raising. Assistance and support of programme partners, as well as that from the academe, helped in developing community skills and potentials for locally appropriate forms of IEC. A theatre workshop became a venue for enhancing understanding and skills at dissemination of SRH issues. Follow-through workshops were conducted with the collaboration of the LGUs, NGO and partners from the academe.

Strengthening the knowledge and skills of POs and local partners was attributed to key CO approaches. A grasp of issues and social and cultural dynamics gained from the CNA and initial community integration are the primary assets for development. This participation kindled their enthusiasm for training and capability

building activities and to facilitate the formation of core groups of POs that later on managed CBIs. The support of *barangay* leaders and health service providers facilitated the coordination for community orientation and assembly meetings. Continuing community education and the integration of RH-related concerns in community activities, as well as the complementing of NGO and LGU/RHU resources and expertise to facilitate RH education and deepen RH orientation (health/economics – RH link), were effective strategies for sustaining community action.

Identifying RH-related needs facilitated project conceptualization and development. The core of community leaders initiated and motivated project planning and implementation with community health workers throughout the process and technical assistance of LGU partners and resource persons were seen as a great help. Regular monitoring proved vital in providing technical assistance for proper project orientation and management.

Improved partnership and networking efforts to coordinate at the municipal level for conduct of activities on RH education, IEC and CBIs facilitated community activities. Monitoring and evaluation were facilitated with regular assessment at the level of PHSSA-CAR. Programme reviews helped partners arrive at a common perspective. Conduct of intensive programme evaluation was significant in directing integrated programme planning and implementation based on a common framework for assessing achievements and areas for improvement, and in refocusing future plans on clear programme direction.

Nonetheless, some challenges were met in the course of PAR and program implementation. The CNA has built-in limitations in terms of IEC inputs and organizing based on the framework and ethical standards of research. Thus, follow-ups were necessary in the succeeding steps of PAR, or with CO as a key approach. Significant gaps in the RH knowledge of CNA participants necessitated deeper probing and more time during FGDs/KIIs. Such gaps were opportunities, since these identified needs for IEC and RH service delivery, which the programme sought to address. Health service providers have basic knowledge and training on MCH and FP but most are still unfamiliar with RH concepts and components. However, low realization and awareness of SRH and rights of the project communities is an opportunity as well for community organizing.

The geographic distance between *sitios* in the *barangays*, especially in Paracelis, limited the reach of CNA findings and had an effect in the balanced representation of CNA participants, and. Inaccessibility and underdevelopment have affected the cost and timetable of the CNA.

Continuing community education has been utilized in disseminating community and sectoral RH needs, issues and concerns. It is also a regular activity of POs through CBIs. However, improved RH knowledge and practices, as well as the assertion of SRH, were constrained by the inadequacy of resources and policies for RH-related services in the communities. The concrete benefits from CBIs paved the way for the POs'/communities' acceptance and participation in the income generating projects.

Although capability building as a means of responding to RH needs was facilitated through community organizing, intensive overall and technical support to POs and community leaders were needed to sharpen their skills on integrated health planning and management. The very limited number of COs also constrained the time and depth of community organizing, taking into consideration the geographical condition of the *barangays*. Modifications in project components and parallel changes in organizational systems and project documents of CBIs in some *barangays*, as well as the dynamics between sitio-cluster members, barangay officials, old versus. the relatively new PO members delayed decision making and project implementation.

Networking was limited to coordination and orientation activities rather than in collaboration. Partners were more concerned about their own deliverables and timelines instead of integrative approaches and collaborative work attitudes among partners to achieve more meaningful results of networking. Gaps and dynamics were perceived to hinder better networking for efficient program planning and implementation of activities.

#### ***Learning with the Community: Specifying learning and insights Drawing lessons and insights from the field***

Given the above factors on facilitation and implementation, the knowledge gained from research, capability building, M & E activities conducted in the course of the PAR and the RH programme were used to improve project performance.

Awareness building and advocacy gained improvement in terms of the depth of orientation through

the POs and the CBIs. However, a more sustained, focused and synchronized advocacy plan can lend a greater impact in pushing for policy support for RH and gender. Although the PO members were aware of their roles, they had yet to find the resolve to take up the challenge.

Integrating the CNA entailed discussions and analysis among the COs and the project staff. This presented opportunities to deepen their understanding of RH issues and dynamics. Activities continuously took shape for awareness and capacity building, and for the CBIs. The need to align and link different activities for the desired RH outcomes and outputs were seen as important for the consideration of COs and partners. Similarly, the need to integrate in continuing community education to underscore the relevance of the programme and further encourage community participation needs more attention.

Initial efforts were made to integrate the CNA results to emphasize the importance of including the identified RH-related concerns in community development planning. Such sessions revealed gaps, skills and integrated approaches for community development planning. This revealed the need for better working relations and for the strengthening of health structures primarily tasked for health planning and implementation. The PAR experience and project implementation proved the necessity of partnerships and collaboration to maximize opportunities, technical and material resources for an integrated health and RH development work in the project areas. The project's progress and success depend largely on this factor. However, experience shows the need for greater efforts to work together based on a common understanding of programme framework and orientation.

The strengthening of RH support networks and the upgrading of local health system provided the impetus and basis to set up mechanisms for increased access to comprehensive high quality RH information and services. The LGUs, local health systems and other partners have been oriented on programme directions. Nevertheless, local implementing partners need to seriously work for integration of plans and activities. The RH component, along with the components on Gender and Population Development planned and worked together to address the gaps in institutionalizing policies, structures and mechanisms to integrate and sustain earlier gains, and to advance the programme towards concrete. Such efforts of programme partners are envisioned to provide the vulnerable communities greater access to and utilization



of high quality integrated RH services, which is part and parcel of basic social service delivery.

### Discussion

This particular PAR experience illustrates its social dimension and ability to solve real-life problems. For example, the identified RH needs and problems stirred awareness and desire to act; provided the context for relevant plans of interventions; and prepared partners for the programme implementation. It contributes both to the practical concerns and the goals of social science. Indeed, there is a dual commitment to study a system and to collaborate with members of the system towards redirecting it towards progress. Accomplishing this twin goal requires the active collaboration of researcher and client, and stresses the importance of co-learning as a primary aspect of the research process. It is an approach that promotes “democracy to become reality” (Ataov 2007, p. 333).

The local partners and community members were aware of the impact that their participation in the process will have on their lives. They considered the differences of those concerned in order to establish support for an effective RH programme. The experience also emphasized the local relevance of public health problems and the multiple determinants of health and disease including biomedical, social, economic, and physical environmental factors. PAR implies “ongoing social learning that ought to lead to personal and institutional transformation”. The PAR process is cyclical and iterative, and research goals are not always known at the beginning of work with a community (Blackstock, Kelly and Horsey 2007, p. 726). The movement toward improved action, according to Wadsworth (1998), involves an imaginative leap from a world of 'as it is' to a glimpse of a world 'as it could be.' Where existing situations benefit or promote some but disadvantage or subordinate others, the creative change may be construed as 'political'. Collie, Liu, Podsiadlowski and Kindon (2010, p.147) contend that “researchers committed to PAR ethical principles must be prepared to adapt the process so that it best meets what the community want to achieve.” Also, Winter & Munn-Giddings (2001) argue that PAR involves the principle of *reflexive critique* which ensures that people reflect on issues and processes and make explicit interpretations, biases, assumptions and concerns upon which judgments are made. Practical accounts can give rise to theoretical considerations through the evaluation process.

Regular and periodic M & E identifies the current gaps and emerging problems in project implementation and operation, and actions to mitigate them. The role of the CO is important in M & E, and in rendering appropriate

technical assistance. However, it serves the organizations and the projects well when the members themselves have developed the skills to monitor their own projects which build their capacity to analyze, draw lessons and plan enhancing measures, thereby generating ownership of the project. Crafting their own process and success indicators is a means of matching the projects' plan of action with the needs and aspirations of. Sustainability of the project therefore is increased with the benefits derived from answered needs.

The experience showed the importance of giving attention to community dynamics and other factors that are external in project development. Relations and coordination with the local political machineries should be developed to level out roles and potential support of community stakeholders in the project. LGU partnership is essential in the sharing of expertise, providing resources, supporting activities, active involvement in M & E, technical support for improved coordination with community partners and development workers. It facilitated the implementation of the projects. Moreover, the LGUs through its network can provide the legitimate representation and participation of the community in development planning and economic programs.

After this, initial efforts were made to integrate the CNA results in order to emphasize the importance of including the identified RH-related concerns in community development planning. Such sessions revealed gaps, skills and integrated approaches for community development planning. This surfaced the need for better working relations and to strengthen the health structure primarily tasked for health planning and implementation. The PAR experience and project implementation proved the necessity of partnerships and collaboration to maximize opportunities, technical and material resources for an integrated health and RH development work in the project areas. The progress and success depend largely on this factor. However, experience shows the need for more efforts to work together based on a common understanding of programme framework and orientation.

Monitoring visits are sources of continuing learning for improving programme performance. It helps identify the progress of project conceptualization and to generate insights on program-related problems and concerns, and strategies/solutions, given the resources and capabilities of the staff. Monitoring and Evaluation facilitates programme integration and determines strategies and approaches in each component, ensuring common programme direction and focus. Integrated planning, implementation and service delivery establish the core message for advocacy that

connects the activities and services together; synchronize the conduct of activities; and allow pooling or sharing of resources. Thus, players' work are complementary to each other for the goal of achieving greater programme impact.

### Conclusion

More than four years of continuing PAR and programme implementation paved the way for the installation of complementing structures and mechanisms intended in achieving program outcomes. The CNA as baseline for integrated planning of programme partners was completed through PHSSA-CAR. Community structures that would oversee CBIs and RH education activities in the *barangays* have been formed, though their partnerships with the Barangay Councils and the BHSs/RHU have yet to be enhanced to make policy formulation and service delivery more responsive to the identified RH needs.

The CNA activities and deepening RH education built community awareness of RH needs and rights that spurred the project barangays to articulate and take on initiatives to address the gaps in resources, information and services for RH. The operation provided an opportunity to access livelihood, resources and services for health and RH. Sustaining their growing RH consciousness and strengthened capacity to access health and RH resources and services has enabled them to increase the clamour for comprehensive health service delivery that includes quality RH information and services.

Programme reviews still lacked an overall perspective and were more focused on each partner or component's list of accomplishments. Strategies for stakeholders to support and complement each other need to be strengthened. Programme M & E has not yet given way to a more integrated planning that should identify periodically monitored and assessed process indicators. However, the experience has shown that PAR can promote co-learning and capacity, and integrates knowledge generation and intervention for their mutual benefit.

The PAR experience has illustrated that empowerment can be attained through the development of common knowledge and crucial awareness. The experience recognized the community as a powerful unit and the process builds on the strengths and resources within the community. PAR also facilitates collaborative, equitable partnerships and involves an empowering process. In this experience, a true collaborative research process showed the investigators and communities working together to define the problem, collect data, and interpret results. This nature of PAR was the major challenge and will continue to

be for all researchers -- that is to design a process which can result in maximum creativity and imagination.

Indeed, PAR, as illustrated by this experience, involves a long-term process and commitment. It is critical for researchers to continue working even when they are no longer funded to do so.

### Acknowledgement

The program where the study was generated from was supported by the UNFPA. The authors would like to sincerely thank the indigenous peoples of the Cordilleras who unselfishly generated the data with us. In the process, we became better development workers as we learned with them. Also, we wish to thank the UNFPA Program officers who assisted us along the way, together with the community organizers cum researchers.

### References

- Ataov, A. (2007). Democracy to become reality: Participatory planning through action research. *Habitat International* 31, 333-344.
- Blackstock, K.L. Kelly, G.J. & Horsey, B.L. (2007). Developing and applying a framework to evaluate participatory research for sustainability. *Ecological Economics*. 60. 726-742.
- Cahill, C. (2007). Including excluded perspectives in participatory action research. *Design Studies* 28, 325-340.
- Collie, P, Liu, J., Podsiadlowski, A. & Kindon, S. (2010). You can't clap with one hand: Learnings to promote culturally grounded participatory action research with migrant and former refugee communities. *International Journal of Intercultural Relations* 34, 141-140.
- Guba, E. & Lincoln, Y. (1989). *Fourth Generation Evaluation*. Newbury Park, CA: Sage Publications.
- Henderson, D. (1995). Consciousness raising in participatory research: Method and methodology of emancipatory nursing inquiry. *Advances of Nursing Science*, 17, 58-69.
- Huberman, A. & Miles, M. (1994). Data management and analysis methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research*. (pp. 428-444). Thousand Oaks, CA. Sage Publications.
- Philippine Health Social Sciences Association-CAR (2006): *The UNFPA 6<sup>th</sup> Country Programme of Assistance for the Philippines: Community needs assessment of barangays of Mt. Province, Philippines*. PHSSA-CAR, Baguio City.
- Polestico, R. (1993). "Participatory Research: Its application to development, gender, sexuality, and reproductive health." In *Gender, Sexuality, and Reproductive Health in the Philippines* (Pilar Ramos Jimenez and Patricia Monina P. Yadao, eds.), Manila: Social Development Research Center, De la Salle University, pp. 3-28.
- O'Brien, R. (2001). An overview of the methodological approach of action research. <http://www.web.ca/~robrien/papers/arfinal.html> (Accessed 20/7/2010)

turn to page 75