

Praxis Paper no. 7

Diary Studies: Methods for understanding poor people's coping with crisis after conflict

By

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TABLE OF CONTENTS

| | |
|--|-----------|
| 1. INTRODUCTION | 1 |
| 2. DIARY STUDIES AND THE CONCEPT OF HEALTH SEEKING PRACTICES | 2 |
| 3. DESIGN AND IMPLEMENTATION OF DIARY STUDIES ON HEALTH SEEKING PRACTICES | 5 |
| 3.1. <i>Study Design</i> | 5 |
| 3.2. <i>How to Select Informants Through a Sampling Frame</i> | 6 |
| Summary of Section 3.1 and 3.2..... | 13 |
| 3.3. <i>Selecting Informants: The Socioeconomic Survey</i> | 14 |
| Summary of Section 3.3..... | 16 |
| 4. DIARY WRITERS, HOME VISITS AND HISTORY | 17 |
| 4.1. <i>The Diary Outline</i> | 17 |
| 4.2. <i>Conducting the Home Visits</i> | 19 |
| Summary of Section 4.1 and 4.2..... | 23 |
| 4.3. <i>Remembering history: Significant Life Events</i> | 24 |
| 5. PLANNING AND SUPERVISION | 26 |
| 5.1. <i>Fieldworkers play a key role</i> | 26 |
| 5.2. <i>Ethics: Intervention versus Study?</i> | 28 |
| 6. ANALYZING CASE STUDY FINDINGS | 30 |
| 6.1. <i>Answers and Insights</i> | 30 |
| Box 1: <i>Mr. Mula's coughing</i> | 31 |
| 6.2. <i>Limitations and Drawbacks</i> | 33 |
| 6.3. <i>Usefulness for the NGOs: Now that we understand – how do we change?</i> | 34 |
| 7. REFERENCES | 36 |
| APPENDIX 1 - GLOSSARY OF TERMS | 37 |
| APPENDIX 2 - THREE CASE EXAMPLES OF DIARY STUDIES | 40 |
| APPENDIX 3 - SIGNIFICANT LIFE EVENTS (SLE)..... | 42 |



1. Introduction

Over the past decade, researchers and documentalists at the Rehabilitation and Research Centre for Torture Victims in Denmark (RCT) have engaged in many research projects analyzing the practices and effects of torture and organised violence (TOV). This has resulted in a pool of methodological skills in collecting and analysing data relating to TOV, which we now seek to make available to a larger audience outside academia and into the development sector. Having a research department integrated into the work of the organisation puts RCT in a unique position where research agendas and intervention can go hand in hand. Apart from producing research of international standards on the prevention and rehabilitation of TOV, the Research Department is also dedicated to collaborating with organisations working with issues of TOV around the world, notably RCT's own partner organisations in the global South.

This praxis paper takes up the methodological issue in relation to a specific research programme, "Histories of Victimhood". This research program was from its inception intended to bridge the academia-practitioner divide (See Buch *et al* 2008). Hence, methods presented here are developed and tested by teams incorporating both practitioners and researchers, both of whom found the methods highly useful and productive. In the paper are found methods that are useful in understanding how people cope with violent lives, how to gain an understanding of communities, how to analyse levels and nature of torture, as well as how to work ethically in dangerous contexts. The objective is that the praxis papers can be of interest, inspiration and utility for practitioners in NGOs in charge of designing new projects. The focus is on practical aspects of implementation, language is kept simple and technical terms are explained in a glossary. Finally, as we will discuss at the end of the praxis paper, the methods here can be employed for other purposes than pure research. One of the participating organisations has, for instance, attempted to integrate the methods in practical service delivery and as documentation techniques.

2. Diary Studies and the Concept of Health Seeking Practices

For organizations like RCT and its partners, whose main purpose is to assist survivors of torture and organized violence, detailed knowledge on the target groups' own strategies, resources and abilities to enhance well-being, health and function is important for securing efficient interventions. Systematic data collection and analysis is a way to obtain such detailed knowledge. Before launching a study it is important to think through and decide what you wish to study, and formulate this in a study question you think you can answer in the end. In our case our core interest was to find some answers to the overall question 'What do our target group do when they feel bad?' Obviously the answers can be very broad. In case they feel bad or get ill people might apply several strategies simultaneously - e.g. visit the doctor *and* follow a relative's good advice on consuming a particular herb – or simply choose not to do anything. One way to get an insight into this diversity of practices is to make close observations for a period of time among the persons we want to know more about, and in this way register health seeking practices. This approach generates detailed knowledge of the variety of options people pursue – and the limitations or hindrances people face in relation to health problems and well-being.

In this working paper we introduce one method for gathering detailed knowledge through conducting close observations, which we call 'diary studies'. The term 'diary studies' refers to a series of observations (through self reporting diaries, home visits and close systematized contact) of and with individuals or families for a period of 6 to 8 weeks. Knowing that poor, often illiterate people might be unfamiliar with or indeed afraid of writing, the 'diaries' are not expected to be long written texts. Rather, the 'diaries' are, in our method, a way to have systematic discussions and conversations regarding concrete, everyday life. They are used as a way of doing field work¹ which registers events taking place in-between the actual visits *and* as entry points to larger ethnographic interviews. The 'diaries' completed by families are then complimented by a second kind of 'diary' kept by the fieldworkers recording the visits and conversations. These field notes are longer and more detailed.

The method described here is suitable for researching a number of issues related to peoples' everyday lives, problems and actions. In our project the focus was on identifying

¹ When we talk of field work here it should be understood as ethnographic field work, which is defined as the study of a particular human society through spending time with people, participating in everyday life and cultivating close relationships to certain informants (Definition from the Britannica Concise Encyclopedia).

and registering the health seeking practices that the informants pursue. By the term ‘health seeking practices’ we mean things people do when they experience a problem or illness. This includes objects they acquire and consume (medicine, herbs, drinks), activities they engage in (pray, rest, massage, baths), places they go to (clinic, church), persons they consult (family, friends, traditional healers), but also the decision making processes along the way, how they get the knowledge of these objects, places or activities - what the costs are – and what the effects are on the experienced problem or illness. Throughout the working paper, we distinguish between *disease* as the underlying material condition and how people come to understand and act on this we call *illness*. These are often not the same or even congruent conditions.²

Compared to the application of a single questionnaire or conducting a single interview with each family or individual, diary studies require more time and manpower. However, the duration and the frequency of the home visits enable a closeness or familiarity with the informants and their daily lives, which is otherwise hard to obtain. The expected outcome is an enhanced understanding of the individuals’ own coping strategies and health seeking practices - and a comprehensive mapping of the family’s social relations and its place in a larger institutional network. This praxis paper is written on the basis of three case studies conducted in 2006 and 2007 by researchers at RCT in Guatemala, South Africa and Colombia (see Appendix 2). In all three cases the same methods and methodological approach were applied as uniformly as possible while allowing for adaptations to the particularities of each field site.

The working paper is based on experiences, challenges and lessons-learned from the three cases and is presented as a ‘step-by-step’ guide on how to conduct diary studies in a developing country with populations that have been exposed to traumatising events. Each chapter is organised with a number of boxes that sums up the steps to be taken in implementation and general cautionary remarks. The boxes can be read alone and hopefully be of practical utility for field staff. We begin by introducing the diary studies, and then move on to discussing the selection of sampling units and informants before we

² Within the discipline medical anthropology we find the distinction between the concepts of disease, illness and sickness: disease is the biological, underlying physical and material condition, which is knowable through signs or symptoms; illness is subjective, knowable to the individual through experience. From these definitions it follows that illness and disease may coincide, but do not necessarily. People have diseases without being ill or assuming sick roles, and they experience illness and take sick roles when they do not have diseases. Sickness is introduced by Kleinman (1980) as a generic term and he sees disease and illness as two different ways of explaining sickness (Kleinman 1978, 1980).

introduce the house visits themselves and how we relate questions regarding the present situation to what has happened in the informants' past lives. The instruments we introduce address the following questions:

- How to find informants from a big group (sampling)?
- How to choose the 'right' ones (socio-economic survey)?
- How to do the diaries (home visits)?
- How to understand crisis historically (significant life events and life histories)?

The paper takes the reader through each of these steps, detailing the general problems that researchers encounter but also the very specifics that are generated in the meeting with populations that have been the targets of torture and organized violence.

Step-by-step

Think through and decide what you wish to study.

Formulate this in a study question you think you can answer in the end.

Think through the kind of data you wish to collect.

Consider the audience your research addresses since it may influence the data you choose to gather – is it for practitioners, donors or policy makers?

Cautions

Diary-studies need more time and manpower than single interviews.

3. Design and Implementation of Diary Studies on Health Seeking Practices

3.1. Study Design

'Diary studies' is a particular version of a field-based case study³. A case study usually involves the detailed study of relatively few persons or items - in this example, the study is of a number of individuals' and families' health seeking practices and the transactions related hereto. Clearly, applying a case study method – as the diary studies – has certain advantages, drawbacks and implications for the quality and nature of the collected material.

Field studies are open-ended by nature and depend to a large extent on the ability of the researcher to improvise within a given register of pre-designed solutions. For example, in our case we were interested in studying illnesses or problems among the informants during the field work period and the pursued actions and practices. The time span of 6 to 8 weeks allows for events to take place or situations to develop; someone can fall ill during the period, another can be cured, and people have time to pursue several healing strategies. Ideally the diary method enables the researchers to observe and understand events taking place both during and between visits. Although it is one method, it combines a number of different data collection techniques: personal observations, use of informants for current and historical data, and plain interviewing.

In this sense, the method is quite flexible. However, it depends very much on the ability, experience, and the ingenuity of the investigator/fieldworker who needs to be able to observe, interview, record and continuously review the material collected. Furthermore, the method also depends on the relationship that field workers manage to establish with informants. This is never a simple task and relationships change according to context and informants. This means that field workers and researchers must be ready to make adjustments as new problems or challenges surface. Finally, the possibilities of biases are ever-present. Informants do not necessarily lie⁴, but they do tell the story they find most

³ For more details on how to do case studies, consult handbooks on data collection like e.g. D.J. Casley & D.A. Lury (1981) *Data Collection in Developing Countries*, Clarendon Press, Oxford.

⁴ The question of lying has haunted anthropology and ethnography for decades (see e.g. *They Lie, We Lie: Getting on with Anthropology* by Peter Metcalf). Our position is that the imperative is not to pass moral judgments on whether people tell the truth or not. Rather, we must understand that only building relationships with the informants potentially prevent lies. Furthermore, it is also necessary to try to understand why informants choose to tell a particular story at a given time. Often this provides an avenue into understand larger societal structures.

appropriate in the moment. The repeated visits to households leave room for such adjustments as well as for considering the logic of what people tell when and to whom.

Step-by-step

Field-based case studies combine several forms of data collection: home visits, repeated observations, interviews, and historic data.

The process is open ended: review collected data continuously and adjust the data collection techniques.

Caution:

Be ready to adjust the data collection techniques according to obstacles encountered in the field.

3.2. How to Select Informants Through a Sampling Frame

Deciding where to conduct the study and how to select the informants – i.e. the sampling frame⁵ – is crucial for the outcome of the research because it will determine the type of people covered by the study, and hence the type of data produced. It would be natural for an organization like RCT with a specific mandate – a situation that applies to most NGOs – to conduct a survey among the population one would really want to cover, for instance among victims of torture and organized violence in treatment at a rehabilitation centre or among members of a local victims association. However, other insights can be gained by broadening the survey to include persons outside the desired target population. For example, in the case of South Africa where HIV/AIDS is rampant - if informants are selected from a poll of patients visiting a health clinic, no data would be generated about the people that might have the disease, but do not seek treatment at the clinic. By broadening the sampling frame to cover the broader population and not only those accessing the service (those who actually come to the clinic), we can enhance our knowledge on the health seeking behaviour of the entire population. The important point is not that one sampling frame is better than the other. The point is that it matters for which questions we will be able to answer. If an organisation providing services to refugees needs to understand what informants do outside the clinic they run, it is natural to chose clients of the clinic. If we need to understand how a population – for instance a village – practice health, we need to choose randomly among all residents.

⁵ A sampling frame should be understood quite literally as the frame that we will be looking through when we choose informants.

In the following is described the sampling technique and selection of informants applied in the three cases referred to in this paper. As we wanted to collect data on broader health seeking practices, we opted for a random selection of informants. A geographical location was chosen as the sampling frame - a neighbourhood, a village and a peri-urban town respectively. Here we did a random sample among the general population. In each case the study area – or sampling frame - was chosen on the basis of a grounded assumption that a substantial part of the inhabitants matched the desired target population. For example, in the study conducted in Colombia the target population was internally displaced people, and the selected sampling frame was a neighbourhood where - according to secondary sources - more than half of the inhabitants are internally displaced.

Step-by step

Decide *who* your target population is (specific group or general population).

Decide *where* to conduct the study (a specific place or within a group).

Consider *how* to select the informants (randomly among the general population or among specific groups).

Cautions

The sample frame determines the nature of the data collected.

Specific target groups cannot tell much about the general population.

Before actually entering the desired study, area approaches must be made to local leaders, establishing meetings with them, and also informing the general public about the survey and the research project through adequate 'publicity'. In one of the Guatemalan case studies this process took more than a month of sustained visits to the community. The visits entailed meetings with authorities where different forms of remuneration or devolution of information to the community were discussed. The process was finalized with a formal presentation to the entire community where the researchers were presented and the work plan was approved. Despite this lengthy process, negotiations were still needed in many of the households, although most respondents felt committed to participate due to the communal decision.

Cooperation from local leaders or organizations might also facilitate access to maps of the locality. For the random selection to be valid, a sample frame of a study area must be

established, clearly delimited and reproduced in a detailed house/street map. If such a map does not exist it can be produced from sketches and transect walks – or bought as a satellite photo. In all cases the map must be verified in order to minimize typical problems or errors such as inaccuracy or that the map is incomplete or has blurred delimitations between neighbouring villages or areas. Be aware that in many localities maps are regarded by people as closely linked to violence, conflict and the state. Maps are crucial instrument in land disputes; armies use maps and they are fundamental in most state interventions. To many informants individuals walking around with maps carry these connotations. Pay attention to this, and be careful with ownership questions, border drawing between communities and location of the houses.

In the case of South Africa, an aerial photo-based map of the area was ordered from a geographical institute; this method was easy and accurate, but expensive. In Guatemala a map was manually drawn on the basis of a local health post's sketches of the area; here verification was very time consuming. In Colombia an existing map of the locality's roads and blocks served as a basis for manually drawing up all plots; also rather time consuming. Remember that maps rapidly become outdated and need to be verified by researchers and field workers before doing the selection of informants. When making and using a map, it is important that all team members read from and contribute to the map in the same way. In South Africa, for example, only one field worker had any experience in using a map, and it took long before all were accustomed to using the map. Maps can be difficult to understand and often do not correspond to how the area appears. Input from all team members is necessary to produce a validated map.

Step-by-step

- Approach and inform local leaders about the study.
- Make 'publicity' broadly to inform the people about the study.
- Acquire or draw a geographic map of the study area.
- Delimit your area of study.
- Walk the area and verify the map.

Caution

- Acceptance and consent from local leaders and people is crucial.
- Maps are rapidly outdated, hence imprecise and need verification.
- It demands experience and training to understand maps.
- Be aware of the connotations maps have for people.
- Pay attention to questions of land ownership and border drawing between communities.

The detailed map enables the researcher to count (enumerate) all houses in the study area and hence to select what is termed a random sample of houses. To do a random selection of houses based on a list of all houses is crucial. The researcher must not begin picking houses because they look interesting, fascinating or poor. To do that would introduce unintended biases that exclude some houses on the wrong basis. Only by randomly selecting the houses all households have the same probability of being included in the study and certain biases are minimized - such as only including accessible houses 'forgetting' the ones located at the periphery of the area. The random selection of houses can be done in many ways. The crucial point is that the selection is done on the basis of a pre-determined system, independent of the area. It can be done for instance by using a function in Excel from Microsoft or the free web based program www.random.org (see next page).



The total number of houses in the sample frame is introduced and you ask for a random listing of numbers (e.g. 40 or 80 numbers - depending on how many houses one wants to cover).

Step-by-step

- Number all the houses on the map.
- Decide how many houses you need to study.
- Randomly select a list of numbers corresponding to houses on the map.

Caution

All houses in the study area must have the same probability of being included.

The randomly listed numbers correspond to the houses that should be covered by the study. The first action is to verify if there is someone living in the house. If nobody is at

home at the time of the first visit you must return again later to the same house. If the house is not inhabited or there are no adults living here, a substitute house is chosen. One way to do this randomly is to spin a pen on the ground in front of the house for which you seek a substitute and go to the nearest house in the direction indicated by the pen point. This process can be repeated until a substitute house is found. Do not select houses that are not appearing on the random list – just because somebody happens to be at home or the house looks poor or ‘interesting’. An alternative strategy is to take the next house on the list of enumerated houses, or one can have a list of predetermined replacements. From now on we will refer to the individuals or families living in the selected houses as ‘households’. By this term we mean a group of people that live under the same roof and cook together - without necessarily being relatives.

On this first approach or visit to the households the purpose, content and objectives of the study is explained in detail to the person(s) in charge of the household in order for them to make an informed decision on whether to participate. We call the person(s) in charge the “head of household”. The immediate reception can range from suspicion to eagerness to be included. Some of the typical questions raised are: ‘Why did you choose my house?’ – a question which is difficult to answer if people are not familiar with the notion of the random selection. In Guatemala field workers explained the process with an analogue to the farmer’s inspection of a maize field (*milpa*). Since he cannot inspect all cobs he makes a more or less random selection of the corn cobs in order to ascertain the overall status of all cobs in the *milpa*. Explained this way informants understood the dynamics and intentions with the process of selection. Others ask questions regarding the potential benefit of participating: ‘What is in it for us?’ Here it is important to clarify what exactly the participants can expect from the study in terms of benefits or assistance. The process continues if the head of household agrees that the household participates. Otherwise a substitute house and household must be identified.

Step-by-step

- Identify the houses whose numbers were randomly selected.
- Verify that the house is in use and adults are living there.
- Explain the purpose of the study to the head of household.
- Make it clear that participation is voluntary.
- Verify if the household can and wish to participate.
- If the house does not enter the study, choose another based on a pre-determined random criteria.

Caution

- Make sure the houses you visit match the ones selected and marked on the map.
- Do not exclude a house because nobody is at home on the time of the first visit.
- Do not select houses or informants because they look 'interesting'.
- Make sure people understand the purpose of the study.
- Do not insist that a selected household participate.
- Clarify mutual expectations.
- Do not change random criteria in the middle of the selection of informants.

On the first visit to the household a card is filled out stating all household members' names, age and sex. This is referred to as a 'rooster card'. This is also the point at which researchers and field workers need to address the question of confidentiality. Many poor people in areas of conflict survive because they manage to remain invisible and their experience tells them that there is danger when outsiders show up with a pen and pencil. It is therefore important to convince them that what they say will not be used against them. Researchers must be aware of the danger they are perceived to represent and not pressure people to participate. Furthermore, if they are pressured into participating, they will in most cases not be very valuable informants; they will represent a diversion of resources and generate a feeling of poor performance on part of the interviewers.

Also, do not use remuneration to generate participation. Remuneration in kind or money, however, may be used if people are expected to spend substantial amounts of time on compliance with a specific research design

Step-by-step

Fill out a rooster card for each household on the first visit.

Address the question of confidentiality.

Make sure it is an open decision whether to participate or not.

Cautions

Respect people's decision not to participate.

Do not pressure people to participate.

Summary of Section 3.1 and 3.2

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|---|--|
| <p>Step-by-step:</p> <ul style="list-style-type: none"> a) Case studies in the form of home visits combine several forms of data collection: repeated observations, interviews, historical data. b) Consider what questions need to be answered before deciding on how to select informants. c) Introduce the study to leaders of the area. d) 'Advertise' the study locally. e) Acquire or draw a map of the study area. f) Delimit your study area. g) Walk the area and verify the map. h) Number all the houses on the map. i) Decide how many houses you need to study. j) Randomly select a list of numbers corresponding to houses on the map. k) Identify the houses that match the randomly selected numbers as seen on the map. l) Verify that the house is in use and adults are living there. m) Explain the purpose of the study. n) Make it clear that participation is voluntary. o) Verify if the possible informants can or wish to participate. p) If not choose another household based on a pre-determined random criteria. q) Talk about confidentiality. | <p>Cautions:</p> <ul style="list-style-type: none"> a. The chosen sample of informants will determine the nature of the data collected. b. Specific target groups cannot tell about the general population. c. Failure to introduce the study to local leaders can endanger both the research, the researchers and the informants. d. Acceptance and consent from leaders and population is crucial. e. Maps are often outdated, hence imprecise and need to be verified. f. It demands experience and training to understand maps. g. All houses in the study area must have the same probability of being included. h. Make sure the houses you visit match the ones selected based on the map. i. Do not exclude a house because nobody is at home on the time of the first visit . j. Do not select houses or informants. because they look 'interesting'. k. Make sure people understand the purpose of the study. l. Do not insist that a selected household participate. m. Clarify mutual expectations. n. Do not change random criteria in the middle of the selection of informants. |
|---|--|

These steps might seem overly complicated and time consuming – in South Africa this process took almost 3 weeks - but they are necessary in order to perform the ground work and the reflections that are needed to ensure a successful research process. While talking to local leaders, elaborating the map and identifying the selected houses, the field workers obtain knowledge of the locality, and the inhabitants have a chance to become accustomed and perhaps ask the team questions. All this serve as an important preparation for the subsequent activities.

3.3. Selecting Informants: The Socioeconomic Survey

Studying health seeking practices through diary studies and home visits demands a relatively small number of participants, as it is unmanageable and demands too many resources to conduct diary studies with 40 to 80 households (the number selected in the random process). Hence, it is necessary to make a further selection based on hypotheses or assumptions as to what matters when people seek assistance. In the present research project we assumed that socioeconomic factors were crucial in determining how people sought help, i.e. the resources they had at their disposal mattered for how they could seek assistance. Here is an important aspect. We did not wish to test *if* socioeconomic factors mattered – which would have made the socioeconomic explanation into a hypothesis; rather we sought to understand *how* they mattered. In other studies informants might be selected according to factors such as age, religion or ethnicity. In this particular study, as we assumed that economic factors mattered, we designed a socioeconomic survey that was administered to the head of household living in the houses selected in the random process.

Step-by-step

Think about which characteristics are relevant for the issue you want to study.

Based on assumptions or hypotheses, design a survey to be administered among the randomly selected households for reducing the number.

Caution

The criteria one chooses to apply when selecting informants influences the data obtained.

In our three cases, the socioeconomic questionnaires used were not identical. On the basis of other questionnaires and experience of the field site, each case developed a brief questionnaire. The questionnaires were discussed with field workers and tested with a few families; adjustments were made, field workers were trained in the application of the questionnaire, and finally a revised version was applied to the randomly selected households. The questionnaires covered, among other issues, the households' composition (members' age, gender and relationships), primary and secondary sources of income, a description of the houses' quality (roof, walls, floor), access to basic services (electricity, water, gas), electro domestic equipment, possession of land and animals if relevant, history of displacements, participation in organizational activities and reception of economic assistance (pensions, grants, remittances).

The questionnaires were brief and could be answered in 15-25 minutes. Often when designing surveys there is a tendency to make the questionnaires too long. This must be avoided. There is no reason to ask people more questions than necessary for the purpose. Furthermore, when designing a questionnaire it is important to be aware of which questions can and which cannot be answered by a survey. There is no point in asking people questions which they cannot understand or answer.

A survey is most suitable when the researcher needs quantitative data. When we want to understand practice, surveys are ill-suited. It is much better to make observations, as is the approach in the diary study. Furthermore, sensitive material is difficult to obtain in a survey. For example, in South Africa, knowing that most people in the village spoke Shangaan (an indigenous language in South Africa and Mozambique), we designed the questionnaire in that language. Because of stigma of Shangaan in South Africa, all participants chose to speak Siswati. On the basis of the survey we would then have concluded that our sample was Siswati speakers. It was only after long engagement with the households that they began speaking Shangaan. The point is not that surveys are useless, but rather that one needs to consider the usability of different methods for different purposes.

Step-by -step

Design the questionnaire in a tailor-made fashion, keeping it brief and to the point.

Test the questionnaire, and readjust it.

Train field workers and let them practice how to apply the questionnaire.

Caution

Questionnaires should not be too long.

Be aware of what kind of data you collect.

Do not ask questions people cannot understand or answer.

Do not overestimate the kind of data we can collect from a survey.

Based on the assumption that households in different socioeconomic strata have different health seeking practices, the socioeconomic survey was used as a tool to stratify the initial 40 (or 80) randomly selected households in three categories: households that were relatively 'well-off', some that were in-between and some that were really poor. In this way an element of targeting was built into the research project. For the further diary research 10 (20) households were selected: 3 of the 'well-of', 4 of the 'in-between' and 3 of the 'poorest'.

Summary of Section 3.3

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| <p>Step-by-step</p> <ul style="list-style-type: none">a) Think about which characteristics are relevant for the issue you want to study.b) Based on assumptions or hypotheses, design a survey to be administered among the randomly selected houses for reducing the number.c) Design the questionnaire in a tailor-made fashion, keeping it brief and to the point.d) Test the questionnaire, and readjust it. | <p>Caution</p> <ul style="list-style-type: none">a) The criteria one chooses to apply when selecting informants influences the data obtained.b) Questionnaires should not be too long.c) Be aware of what kind of data you collect.d) Do not overestimate the kind of data we can collect from a survey.e) Do not ask questions that people cannot answer. |
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4. Diary Writers, Home Visits and History

4.1. The Diary Outline

After having been through the process of selecting households that will take part in the diary studies, the home visits can begin. As mentioned above, diary studies actually involve three different forms of data collection techniques: 1) the informants fill in diaries; 2) the field workers interview on the basis of the informants' entries, and 3) the field workers make observations and writes notes. Moreover, as above mentioned, they can be supplemented by observations, interviews and historical data. This will be explained in the next chapter.

In relation to the actual diary writing it is necessary to appoint a 'spokes person' in the household. In some cultures the male head of household would normally take the role as 'spokes person' for the family, but he might not be the most knowledgeable on health practices nor available for the subsequent visits. A way forward is to ask for the person who is most knowable about the household members' health seeking practices, i.e. what we call the household's *primary caregiver*, to be the spokes person. In some households the primary caregiver might be an elderly person who is illiterate; here a solution could be that a younger person notes down the elder person's observations. No matter who is chosen as spokes persons or/and diary writers there are important questions regarding power struggles involved. We will deal with these below. For now, we are going to concentrate on the diary.

Box: How does a *Diary* look? Example from South Africa

| When? | Who? | What? |
|-------------|--------------|--|
| 28 Mar 2006 | Whole family | The roof of the house was leaking water and we couldn't sleep. |

There are a number of steps that should be observed in producing a diary. They include:

- The notebook has pre-printed headlines on each page (who/when/what).
- Entries should regard issues that the research explores. In our case the entries regarded any illness or other issues that cause suffering among the household members.

- Entries should be brief (in order not to tire the diary writer) and made daily during a determined time span. If people write a lot, do not discourage.
- Focus is on who/when/what: Who did it happen to? When did it happen? What was wrong?

It is important that the selection of the responsible diary writer doesn't create conflicts in the family. In Guatemala we had a case of a wife who accepted to participate without her husband's knowledge, and subsequently he got very angry with her. The diary should be introduced as a book for the whole household where health issues regarding all household members are noted – and not a place to write about 'family secrets', like suspicions of adultery, which could cause crisis in the family. However, no matter how much one would want not to cause conflicts, many poor families are in a perpetual state of crisis already. Field workers must be aware and reflexive about the fact that their presence can cause these problems to stir again.

To ensure the utility of the diary notes it is crucial to explain the purpose of the diary in depth. One way to do this is making a role play with the households, letting the household members ask the field worker questions about his or her actual health situation and possible actions he/she has taken. In South Africa, one field worker introduced the diaries to the families. After the initial introduction – after which the family did not grasp the meaning – she filled in the diary herself, handed it over and asked the family to question her. Most of the questions they asked were questions that the field worker would also have asked. Thus, turning the tables helped the family to understand the purpose and in the long term created better data. It also enabled a more equal relationship between field workers and informants. This, like the sampling, is a difficult process. In most cases, explaining the diaries to the participating families took several hours.

Step-by-step

Prepare diaries beforehand by writing in the headings: **What** (the problem), **Who** (has the problem) and **When** (it occurred).

Introduce the diary as the 'property' of the entire family, and not a place for family secrets.

Decide together with the family who is the spokes person – i.e. most knowable of health seeking practices.

Use time to explain for the family the purpose of the diary, and how to fill it in.

Explain in detail the purpose and functioning of the diaries.

Use role play if necessary.

Caution

Be aware that not everybody are comfortable in writing.

Be aware of internal power struggles in the household and how the visits play a role in these.

Do not rush the explanations. Although it takes time, it is time well spend.

4.2. Conducting the Home Visits

After introducing the diaries, home visits can commence. The period in which home visits are conducted can vary according to resources and interest. However, a certain period must be considered to allow incidents to unfold though without tiring out informants. In our experience, six to eight weeks were suitable. If resources are limited it is preferable to allow longer time to pass between visits. Practical issues such as the size of the study area, the number of households covered, means of transportation available and the number of field workers available will influence how many home visits are feasible per day. Health problems such as diarrhoea or malaria recurrent in resource poor households are often seasonal, e.g. depending on the rainy season, and the findings might reflect this.

Each visit can easily take an hour in order for the persons to be able to explain what has happened to them, and for the field workers to ask additional questions. It is important to have time to listen and let people talk and tell their story in detail. Visits conducted with translators are more time consuming. Ideally the households are visited every 48 or 72 hours in order for people not to forget what has taken place since the last visit, but again, too many visits might tire the household. As explained under the section 'Diary', there might be a 'spokes-person' for the family – the primary care-giver - who does the talking (even if this person is not the one actually writing), but others can join the discussion and supplement – or we can ask them if it is justified. It is recommended to maintain the same

diary writer throughout the entire period, but it might turn out that it can be difficult to meet some of the persons in the homes, due to work or travel; others might lose interest and decide to leave the project.

During each visit the field workers read all entries noted in the diary since the last visit. These are copied to the field workers own notebook (who/when/why). All the entries in the diary are discussed with the diary writer and additional questions asked. We suggest that a check list of questions is generated. In our project we always asked informants “where did you go?”, “what did they say to you?”, “what did you think about that?” and “what did it cost?” After each visit an appointment can be made for when the next visit will be. Weekends are typically better for visiting households where the adults are working.

The diaries and home visits help the researchers understand practices of households from their own perspective while they unfold. However, there can be limitations that researchers and field workers must be aware of. Firstly, because diaries only capture what people choose to tell, there might be issues that are not covered. In South Africa there was a tendency that informants chose not to tell about tabooed health problems – often related to sex and reproduction. Secondly, as the diaries focus on ongoing events, some chronic, long lasting illnesses were ignored or forgotten. Likewise, the focus on events taking place can also silence the more trivial recurrent health related problems like e.g. headache and menstrual pain. Being aware of this, the field workers can ask questions to the more general well-being and try to uncover chronic problems or past experiences of illness in the family. To facilitate this process additional data collection techniques can be used, like for example the Significant Life Event (SLE) questionnaire that is introduced in the last section of this chapter.

Step-by-step

Home visits must be conducted over a period of no less than six weeks with regular intervals.

Each visit may take an hour to allow people to elaborate on their diaries and field workers to ask additional questions.

The visits and interviews should be conducted with confidence as a friendly conversation.

A check list of questions should be generated.

The success of a multi-visit study as this depends on the establishment of a genuine bond between field worker and diary keeper.

Prompt for chronic illnesses which people may not think of disclosing.

Caution

The period should not be less than 6 weeks.

Too frequent visits might tire out the informants.

Be aware that health in resource poor households is seasonal.

The household's 'toleration and level of participation in the study depends on whether it requires suspension of normal activities (e.g. farmers are often very busy).

Some might lose interest and decide to leave the study.

Pay attention to issues that people do not mention (both tabooed or forgotten issues).

After a few visits to each household it becomes clear that the informants write very different things in the diaries. Some note the smallest details – even if the instruction was not to write too much but only make brief entry points – others write very short and precise entries, others again do not write anything! It is important to keep in mind that for many of the informants, writing as a way of expression is not a costumed practice and might make them feel odd or uncomfortable. Some simply forget to record events, and by asking if they have forgotten something this can be included. Typically, after having visited the household a few times, the exercise changes character; now the field workers are familiar with the household members and their actual health status and can easily ask questions to this without relying so much on the diary entries. Often people stop writing and the rest of the visits are managed verbally. This is no problem, in many cases time is a constraint, and continued participation may depend on the oral format.

A good entry question is, for example: "Has anything happened since our last visit that has made you feel bad?" This is an open question and people could mention illness, a fight with someone or a bad dream. Clearly, many incidents come to the fore in the

conversations held during the visits – more so than in the diaries. This additional questioning hopefully develops into more informal conversations where people disclose things. The development of these conversations depend in each case on the relationship between the household and the field workers, one might get along very well with some and not so well with others. Thus, the flow of information is different in each household. Also, there might be variations from visit to visit depending on the mood of the persons involved and the time available or maybe present visitors or children can restrain conversation.

The field workers must take detailed notes of the conversations but also pay attention to the informants' gestures and facial expressions when talking. For example, if new interesting issues appear in the conversations, the field workers should take note of it and be able to bring the issues up on a later occasion. It is important to be aware of silences in the informants' narrations. For example, some problems, illnesses or diseases may not be mentioned by people in the diaries or during the initial visits because they are taboo or too personal. However, after several visits to the family, some of these issues might appear in the conversations and it will be possible for the field worker to ask more in depth.

We found that clearly defined starting and ending points makes it easier to finalize and 'leave' the families upon finalization of the research project. It was an issue of discussion whether the families should receive monetary remuneration for keeping the diaries. In the end we decided to give each family a photo of themselves, a CD with a recorded interview, a letter of gratitude for their participation, and in two cases also a bag of groceries. In all cases we also chose to give some intellectual feed back, e.g. a history of the area, a workshop introducing the results or a baseline study.

Step-by-step

Try to make the visits focus on both current and past health problems.
Plan ahead on how to finalize the relationships when the project ends.

Caution

Finalizing the relationship can be problematic.

Summary of Section 4.1 and 4.2

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| <p>Step-by-step</p> <ul style="list-style-type: none">a) Prepare diaries beforehand, focusing on what the problem is, who has the problem and when it occurred.b) Introduce the diary as the 'property' of the entire family, and not a place for family secrets.c) Use time to explain for the family the purpose of the diary, and how to fill it in.d) Use role play if necessary.e) Home visits must be conducted over a period of no less than six weeks with regular intervals.f) Each visit might take an hour to allow people to elaborate on their diaries and field workers to ask additional questions.g) The visits and interview should be conducted with confidence as a friendly conversation.h) A check list of questions should be generated.i) The success of a multi-visit study as this depends the establishment of a genuine bond between field worker and diary keeper.j) Prompt for chronic illnesses which people might not think of disclosing.k) Plan ahead on how to finalize the relationships when the project ends. | <p>Caution</p> <ul style="list-style-type: none">a) Be aware that not everybody are comfortable writing.b) Be aware of internal power struggles and how the research plays a role in these.c) Do not rush the explanations. Although it takes time, it is time well spend.d) The period should not be less than 6 weeks.e) Too frequent visits may tire out the informants.f) Be aware that health in resource poor households is seasonal.g) The household's 'toleration' and level of participation in the study depends on whether it requires suspension of normal activities (e.g. farmers are often very busy).h) Some may loose interest and decide to leave the study.i) Pay attention to issues that people do not mention (both tabooed or forgotten issues).j) Finalizing the relationship can be problematic. |
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4.3. Remembering history: Significant Life Events

The described diary studies and home visits focus on the present. They mainly elicit data on incidents regarding current problems and suffering. As already mentioned, the method can be supplemented by other data collection techniques as for example 'Significant Life Events' questionnaires, observational data and qualitative interviews. In regards to the two later data collection techniques there is no particular format or procedure to follow. Simply, whenever field workers make observations during the home visits these should be noted down and, if they prove to be relevant, brought up with the household at a later occasion. The qualitative interviews can be conversations on specific issues, events or life trajectories depending on the specific research interest. These can be recorded, and one can follow a more or less structured list of questions if it seems relevant for the particular study to do so. However, the 'Significant Life Event' questionnaire requires a bit more introduction.

The Significant Life Events (SLE) instrument is a questionnaire (see appendix 3) that takes the interviewed person through his or her life by asking to specific domains (family, work, mobility, organizations, etc.) and placing the events on a timeline. The interviews are open-ended but follow systematic recording principles in the form of a scheme (see Balán et al. 1969). By this rather schematic exercise the field worker acquires an overview of the individual's personal history, life trajectory and important events. This facilitates raising questions in later interviews on events that took place years back, e.g. an important illness episode or a chronic problem. For individuals who are not used to thinking and narrating their own biography in relation to specific years, it can prove rather difficult to place lived events in timely sequences. Through the questioning the interviewer can assist in this task, e.g. by asking 'how old is your daughter now' rather than asking in which year she was born. Specific national or local events known by the interviewer may also serve as historic markers indicating exact years, e.g. rather than asking 'where did you live in 1984' one could ask: where did you live *before* the war?

We found that the information about past experiences and health problems, which came to the fore through the SLE-information, proved very useful for the understanding of present days' situation and sometimes detect chronic health problems.

Step-by-step

Make observations in the homes.

Ask or interview the families about specific issues.

Conduct a SLE-interview about important past events.

Caution

Do not rely on only one technique.

5. Planning and Supervision

5.1. Fieldworkers play a key role

Field workers are key to the implementation of the study and the quality and quantity of the collected material. To secure optimal outcome, several aspects are important: 1) careful selection of field workers, 2) clear communication of the study content and purpose, 3) adequate training of field workers. Firstly, selection of field workers is important because the form, duration and depth of the household visits are highly influenced by the relationship established between the family and the particular field worker. This important point is treated in detail below. Secondly, it is crucial to plan the phases of the study in detail and communicate this to field workers, e.g. through a detailed written field manual or work guide. This could also be the place to describe the various data collection techniques thoroughly, clarify their sequence, implementation process and purpose. Thirdly, adequate training of field workers imply, for example, that field workers become used to the data collection techniques by practicing in advance how to apply the questionnaires and receive feed back from the supervisor. It is also a good idea to practice on each other. During implementation it is important to sustain a dialogue between field workers and supervisors on obstacles and challenges encountered.

When selecting the team of field workers there are several aspects to consider like gender, age, ethnicity, language skills, cultural and professional background. These different attributes shape the field workers' ability to bond with the informants either as 'outsiders' or 'insiders', same or opposite sex, etc. Diversity of the team of field workers should be regarded as a strength in any research project that inquires into peoples lives. We experienced the insider/outsider problematic in Guatemala where field workers consisted of middle class university graduates from the city who arrived to a rural indigenous village and had to work hard to get accepted and be able to establish a closeness or intimacy with the informants. Of course, examples also exist of the opposite where it is an advantage to be 'outsider' because the respondents might be embarrassed to talk about issues of sensitive nature to someone from the same village. In South Africa, field workers came from the study area, lived in similar conditions and had had a similar life trajectory, and this gave some field workers a need to create distance to the informants through arrogance.

Within the team it is possible to rotate the field workers so that e.g. both male and female field workers visit the family. However, such alterations need preparation in order to avoid that a 'new' field worker arrives and begin asking the same questions once more, which is very tiresome for the informants. Hence, notes from previous visits written by another field worker must be read carefully, previous diary entries read through, etc. Such alterations between field workers thus require a rather careful note taking in order for the others to understand the context. A negative effect of rotating field workers is that the trust relationship established between the field workers and a household is broken when a new person enters the house, and it takes time to establish a new. This can probably be minimized if initial visits are made by several field workers at the same time so that the families become acquainted with the entire team.

Note taking by the field workers is absolutely central for the method, and part of the triangulation of data. Hence, field workers must be trained in note taking together with having a good sense of the issues at interest for the study and asking additional questions to complete the information. We recommend that up to half the allocated time for field work is dedicated to writing notes, especially if the field workers are not used to writing. The writing is a reflexive process for the field workers – it can make them think about themselves, make connections, see things in a new way. Being in these intimate relations is very hard work and can even be disturbing or traumatizing to the field workers. The field work process is very much affected by ups and downs. It is normal that as time passes, field workers experience a field fatigue, i.e. they begin to feel tired of the field. This is due to the working conditions (long working days, exposure to wind and weather), to the content of the work (the amount of problems people have, the poverty, the closeness to other peoples' suffering) – and maybe also a feeling of helplessness, 'how can I help these families?'

Step-by-step

Think through all practical issues (transportation, area size, number of households).

A diverse team of field workers should be selected.

Field workers must be trained in the data collection techniques.

Field workers must be trained in note taking together with having a good sense of the issues at interest for the study and asking additional questions to complete the information.

Up to half the allocated time for field work is dedicated to writing notes, especially if the field workers are not used to writing.

Debrief field workers and evaluate on a continuous basis.

Make sure to allow field workers to express feelings and frustrations.

Cautions

Field workers that are “outsiders” may (not) have problems bonding with people.

Fieldworkers that are “insiders” may be (too) close to the informants.

Field workers can be very affected by the intimate relations.

Field work is very hard work and can even be traumatizing to the field workers.

The field work process is very much affected by ups- and downs.

Be aware of field fatigue.

5.2. Ethics: Intervention versus Study?

One way to overcome the divide between interventions and mere study is by making sure that the households can receive some counselling during the process. In our research projects we chose to adopt a participatory methodology involving both practitioners (NGO-workers) and researchers through working with local partner organizations that had work experience from the study areas and knowledge of the victims' situation in general (Buch *et al* 2008). If the study is planned and directed by a national or local NGO, it might be important to select field workers with good knowledge of the area and professional contacts that enable them to assist and counsel the households. For example, in one household in South Africa we met a young child who was not enrolled in primary school, and the field workers assisted the family in the administrative process of getting the child to school.

It is possible that the visits and the repetitive asking for the actual status of a certain illness or problem can influence peoples' behaviour and perhaps make them more focused on 'doing something' in order to be able to answer our questions of "What has happened since our last visit?" In this way the research process obviously 'influences' the households' situation and actions, but on the other hand it would be unethical to merely 'observe' and not interact with the households.

Step-by-step

Recruit field workers with local 'on the ground' experience.

Make sure participating households can receive some counselling during the process.

Caution

Peoples' actual behaviour is probably influenced by the research form.

6. Analyzing Case Study Findings

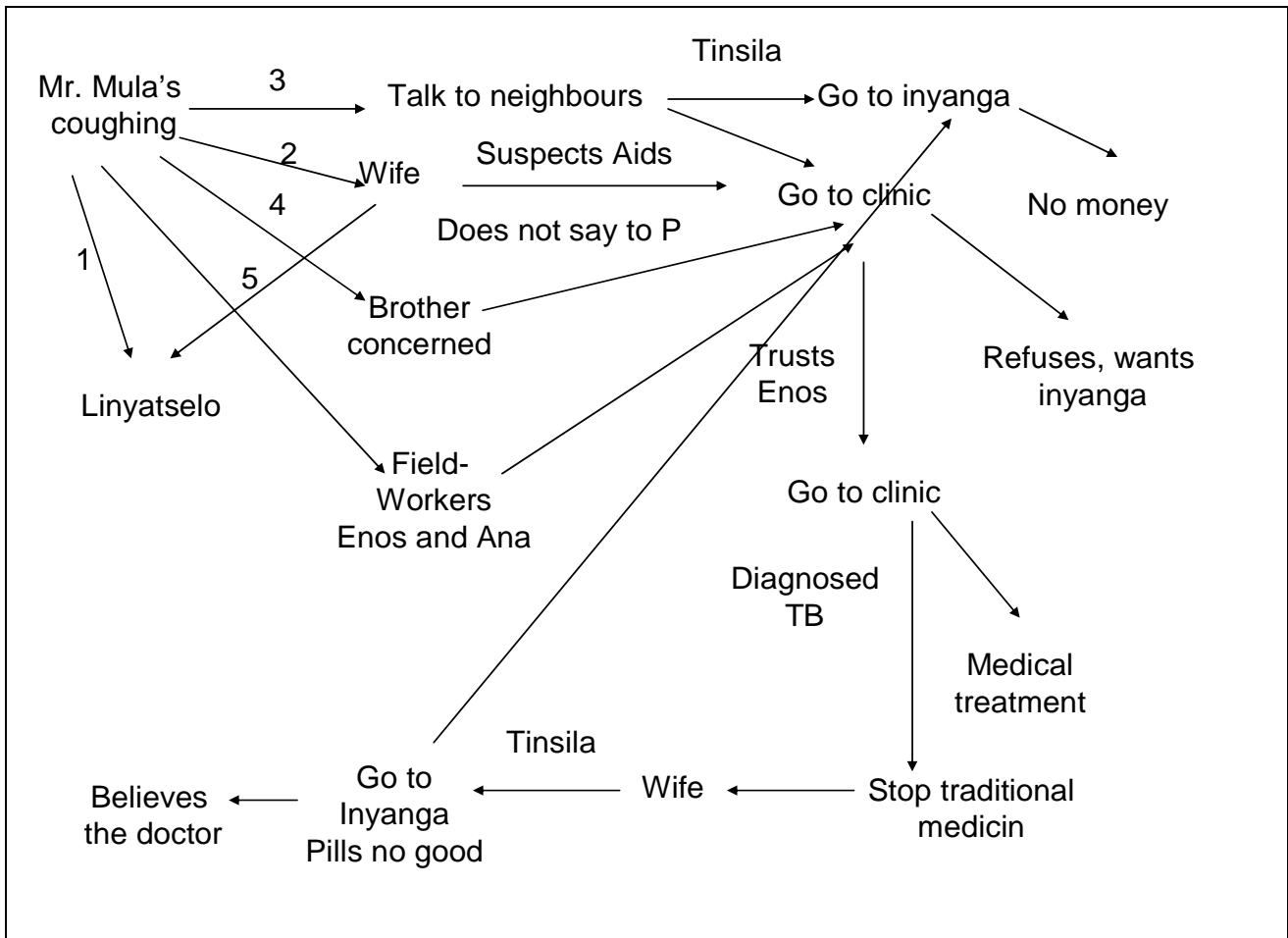
6.1. Answers and Insights

The research or structured data collection, described in this praxis paper, has focused on people's health seeking practices, and the answers and insights that can be gained from this type of study include:

- Problems, Sickness and Illness: What health problems do people have? How do they understand these? Which are the main problems or challenges the households identify with in their everyday life.
- Decisions and Motivations: Which decisions are taken in relation to sudden or chronic illness? What are the motivations for or reasons to the decision (belief systems, economic dispositions, time constraints, practical obstacles, limited knowledge).
- Social Relations: Who do people go to for advice and help? Who do they interact with regularly (to obtain knowledge, money, medicine, herbs, cure)?
- Institutional Networks: Which institutions are present in the area? And where do people go for alleviation and/or cure?
- Healing activities: What do the families consume? (medicine, drugs, herbs). What do they practice? (prayer, baths).
- Health Outcomes: What are the (perceived) effects of the pursued health seeking practices?

To exemplify the knowledge and insights obtained in a particular setting we will present the case of Mr. Mula. Mr. Mula is the head of household in a South African peri-urban town, and after 6 weeks of diary studies and home visits, observations and several interviews, both with Mr. Mula and his wife, the following story emerged about his cough and the actions taken in relation hereto.

Box 1: Mr. Mula's coughing



The diagram shows the various persons that Mr. Mula sought advice from in relation to his cough, what the persons advised him to do, what he did and what happened hereafter. The cough had started long before the fieldworkers first visited Mr. Mulas house, and previous events and actions are included based on information from Mr. Mula himself and his wife. During the 6 weeks diary studies the field workers had an opportunity to follow the decision making process more closely. Bothered by a permanent cough, Mr. Mula had digested a local herb *linyatselo* (1). He also discussed his condition with his wife (2). The wife suspected, she told the field workers of hand, that Mr. Mula might have Aids, as he was sleeping around on the farms he was working on. She did not mention this to Mr. Mula. Mr. Mula also talked with some concerned neighbours (3), some advised him to consult an *inyanga* and others to go to the clinic. The *inyanga* is a traditional healer, and this treatment was rather expensive, whereas the local clinic offered free treatment. Mr. Mula consulted his brother, a migrant worker in Johannesburg who was very concerned and also advised him to visit the clinic (4). Mr. Mula himself however refused to go to the

clinic and opted for the *inyanga* in the first place, but the lack of money ruled out this option – the *inyanga* wanted R100 for the cleansing needed to rid Mr. Mula of the suspected *tinsila*, which is a disease related to the breaking of taboos. One attracts it after having had sexual intercourse with those in mourning after a relative's death or eating food prepared by a mourner. Mr. Mula, in so many words, admitted to have been breaking such taboos, so he was quite sure that *tinsila* was the problem. It was only after a series of home visits by the field workers Enos and Anna that Mr. Mula gained confidence in Enos (male) and told him about his permanent cough. Enos advised him to go to the clinic (5), and Mr. Mula finally did so. At the clinic he was diagnosed with *tuberculosis* and was offered a medical treatment. He refused to be tested for HIV/Aids but he accepted the medication and stopped the traditional medication. However, his wife, particularly concerned with his sexual practices and their domestic problems, strongly opposed this conclusion as tuberculosis in no way addressed these family dynamics. She insisted that she had seen this kind of tuberculosis medication before and that they never worked. She suggested instead that Mr. Mula should go to the *inyanga* as the *tinsila* diagnosis at least positioned the sexual conduct centrally.

What does this case tell us? Well, it becomes apparent that the local health clinic is not the first option for Mr. Mula - even if treatment is free – it may not even have been an option at all if the fieldworkers had not been present. Like Mr. Mula, many people in South Africa prefer to seek treatment with alternative or traditional healers to the detriment of bio-medical treatment. Clearly, the option of consulting a traditional form of treatment is only a real option if the person or the family has sufficient money to pay such treatment. Through the diaries and home visits, the field workers gain a detailed insight into these practices and processes. Divergent positions within households – e.g. the wife who suspects Mr. Mula has aids, and Mr. Mula who refuses to visit the clinic – can be unveiled. Ongoing transactions - such as advice, suggestions and preoccupations - circulate, economic conditions determine the options that can be pursued and, finally, the field workers' presence and counselling in this case played a role in shaping the practices of Mr. Mula (Jensen and Sikhauli 2006).

For a health NGO worker, planning an intervention in a similar area of South Africa, the knowledge generated can provide a detailed understanding of the context and current health seeking practices. The fact that Mr. Mula refused to be tested for Aids, which is

rampant, and that his wife advised him to stop the medication, thereby subjecting Mr. Mula to a multi-resistant form of tuberculosis which is very hard to treat, is and should be a concern for bio-medical practitioners. Hopefully, this insight will bring us closer to designing interventions that acknowledge and address local health seeking practices. If we cannot expect that people consult the clinic – even if it is free – new projects and interventions should incorporate this knowledge and look for new ways forward.

6.2. Limitations and Drawbacks

One of the main problems with case studies is to what extent the findings can be generalized. On the first level, how can the findings be generalized within the study area itself, e.g. what is the status of data about the whole village obtained from a few selected respondents. Whether a statement can be made about the whole population in the study area, from maybe 10 or 20 selected household case studies, depends on the areas homogeneity. But by going through the process of first randomly selecting a larger number of households and from there select the stratified cases, this problem is sought solved. Secondly, how far can the findings from a study of a particular area or community be generalized to regions, countries or even across countries? This again will depend on the particularities of each study area.

In our research project covering Guatemala, Colombia and South Africa, the initial findings show great similarities between the informants' lived lives, i.e. their experiences of war, violence and displacement, and actual and past material deprivation and marginalization. Differences exist in how these experiences are understood and imbued with meaning in each setting, e.g. different interpretations and explanations of the lived violence. For example, do the victims understand the experienced armed conflicts in racially, ethnic or socially motivated terms? On the level of actual health problems, similarities are striking in relation to constrained access (lack of money for transport or medicine, experiences of discrimination from health personnel, inadequate identity papers - denied access), limited knowledge (of options and rights to treatment), prioritizing (will not lose a day of work to go to the hospital), and utilization of several health systems simultaneously (biomedicine, traditional, alternative, religious, self-medication).

6.3. Usefulness for the NGOs: Now that we understand – how do we change?

Knowledge and insights generated by research and rigorous data collection is a prerequisite for targeted context specific interventions. But the transformation from knowledge and enhanced understanding into practice is not straight forward. Firstly, we could begin by making a distinction between incorporating new knowledge that is gained through research, like the knowledge of the health seeking practices, and the skills of how we acquired that knowledge. In this way, research is both about results and processes, i.e. methods and instruments. In this section, we primarily discuss the latter, as it has direct bearings on the discussions of diary studies, home visits observations and significant life events instruments. These, we argue, might be integrated into organisational work as part of normal service delivery, documentation of interventions, so popular with funding agencies these days, and a constant organisational reflection on practices and assumptions. Using research methods is not necessarily the same as doing research and thereby having to fulfil strict research criteria for selection and sampling. Organisations might also use the methods as inspiration to normal work. This was attempted in the South African organisation, which participated in the research programmes, Masisukumeni Women's Crisis Center (MWCC).

Members of the team from MWCC felt very strongly that some of the research instruments could strengthen their organisation and deepen their intervention, if they could 'bend' the rules of research slightly. This is possible if one, then, is ready to pay the price. For example, MWCC did not care too much for sampling because they already had a client group. To make random sampling would make little sense. The price willingly paid was that nothing could be said about the larger group. The MWCC members identified the following strategy in collaboration with the researcher:

- *Expand* some of the research instruments, which had been adapted to the purpose of intervention rather than research, as part of counselling to a selected group of counsellors on a pilot basis. These methods included home visits, simple socioeconomic surveys and brief life histories. The pilot project was targeted at the group of clients who received Anti-Retroviral (ARV) medication after rape.
- *Organise* a workshop for selected staff members who are lay counsellors, which would be facilitated by the research team, with the aim of explaining the research process, methods and instruments and exploring the usefulness of the research

method and instruments to the daily work of counselling and assisting survivors of gender based violence.

- *Establish* a learning group/network within the organisation who would volunteer to incorporate and apply the methods and instruments in their work and meet to reflect on and analyse their experiences and findings.
- *Incorporate* the discipline of documentation and some of the research methods as part of existing management supervision and monitoring practices, such as in case supervision.
- *Organise* bi-annual forum of staff dedicated to reflection on practices.

Step-by-step

It is possible to 'bend the rules' to use the instruments of research in intervention, documentation and reflection.

Caution

To 'bend the rules' has a price in terms of what one can conclude from the results. One must carefully consider what the consequences are for what one can say on the basis of the knowledge acquired.

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Appendix 1 - Glossary of Terms

Chapter 2

| | |
|--------------------------|---|
| Diary Studies | A series of observations (through self reporting diaries, home visits or close systematized contact) of and with individuals or families for a longer period. |
| Health Seeking Practices | Things people do when they experience a problem or illness in order to get better. |
| Target group | The group of people one would like to study or the beneficiaries of one's interventions. |
| Well-being | To be and feel well physically and mentally. |
| Ethnographic interviews | Interviews that are more like informal conversations: there are no predefined questions, but maybe certain areas of interest can be raised during the talk. The fieldworker or researcher often talks to the same person on repeated occasions. |
| Field workers | People working in the field who has been trained to gather information for the study carried out in the field. |
| Field notes | Important information written down by the field workers recording their observations, interviews, etc. |
| Informants | The persons we study and interact with. |
| Disease | The biological, underlying physical and material condition, which is knowable through signs or symptoms. |
| Illness | Illness is subjective, knowable to the individual through experience. |
| Sickness | A generic term. Disease and illness are two different ways of explaining sickness. |
| Questionnaire | A form with research questions where the answers of the informants are registered. |
| Coping Strategies | Ways of dealing with and acting towards challenges of life. |
| Mapping | A description of the study area, e.g. the institutions present. |
| Sampling units | For example, houses, households. |
| Socio Economic Survey | A survey based on a questionnaire which asks people about their social and economic conditions. |
| Home Visits | Visiting informants in their home. |
| Significant Life Events | Is a questionnaire (see appendix 3) that takes the interview person through his or her life by asking to specific domains (family, work, mobility, organizations, etc.) and place the events on a timeline. |
| Life History | A person's narrative about his or her life. |

Chapter 3

| | |
|-------------------|---|
| Case study | Usually a detailed study of relatively few persons or items. |
| Open-ended | The end result or answer is not determined on beforehand. |
| Bias | A tendency to present something in a particular manner according to one's personal opinions. |
| Sampling Frame | The broader population from where you identify your informants, e.g. a map of the study area with <u>all</u> the houses drawn onto it. |
| Randomly | Coincidentally; for example, only by randomly selecting the houses, all households have the same probability of being included in the study. |
| Survey | A study covering a larger number of people who are chosen randomly. |
| Remuneration | Rewarding informants for their participation. |
| Transect Walks | Walks around the study area together with the local people who explain about the area, e.g. who owns what land or where the division line to the neighbouring community is. |
| Satellite photo | An aerial photo of the area taken from a satellite which can be used for producing a map. |
| Enumerate | Count for example all the houses and give each a number on the map. |
| Household | People living together and share food on a daily basis, not necessarily relatives. |
| Head of household | The person controlling the household. |
| Rooster card | A simple list of all the household members' names, age and sex. |
| Confidentiality | The information that the informants give to the field workers and researchers is not shared with anybody else, and the notes are kept in a secure place. |
| Stratify/strata | To divide households into separate groups, e.g. according to level of income. |
| Tailor made | An expression for adapting a method or e.g. a questionnaire to a certain context, making it fit. |

Chapter 4

| | |
|--------------------|---|
| Spokes person | The person in the household speaking on behalf of the rest of the members. |
| Primary care giver | The person who primarily take care of the family and is most knowable about the household members' health seeking practices. |
| Role play | A play where the different participants try to play another role, e.g. the informants ask questions to the researcher or the field worker about their health. |
| Taboo | Issues, things, events or beliefs that are normally not supposed to be done or talked about. |

Chapter 5

| | |
|------------------------|---|
| Significant Life Event | A questionnaire (see appendix 3) that take the interviewed person through his or her life by asking about specific domains (family, work, mobility, organizations, etc.) and places the events on a timeline. |
| Field fatigue | When field workers or researchers feel tired of working and being in the field. |

Chapter 6

| | |
|--------------------|--|
| Peri-urban | Area at the outskirts of the urban zone where people may have the possibility to do some agricultural work. |
| Linyatselo | A local herb used in South Africa. |
| Inyanga | A traditional healer in South Africa. |
| Tinsila | A disease related to breaking taboos, e.g. after having had sexual intercourse with those in mourning after a relative's death or eating food prepared by a mourner. |
| TB | Tuberculosis, a contagious respiratory disease. |
| Traditional healer | Examples: Sangomas, inyangas, diviners, shamans, curanderos. Those without a formal recognized medical background who treat and heal people. |
| Bio-medical | Formal medical science, doctors and pharmaceutical treatments. |

Appendix 2 - Three case examples of Diary Studies

As part of a larger research program, conducted by researchers at RCT and partner organizations in Guatemala, South Africa and Colombia, three case studies have been conducted in 2006 and 2007 applying the method of diary studies in diverse contexts. The three countries were selected because they share characteristics: conflict or post-conflict experiences and large groups of victims together with the fact that Guatemala and South Africa are both extremely racially divided. The research design and methodology have been uniform, and the actual methods, as well as the way the data is organized, are as similar as possible in order to make the three cases comparable.

In Guatemala and South Africa, the research was implemented in coordination with local partner organizations. Both partner organizations are NGOs with a long trajectory of working with victims of violence: ECAP in Guatemala works with victims of the civil war, particularly Maya Indians, and Masisukomeni in South Africa works with Mozambiquean refugees and female victims of sexual and domestic violence. The field workers had diverse backgrounds and professional training – some were university graduates, others social workers with little training. But the important aspect here was their deep knowledge of the general problematic in the area of study, local languages, the informants' life conditions and history of the particular field site. The following is a brief presentation of each case and the particular circumstances we had to take into account and adopt the method to in each site.

a) Guatemala – Rural area, village Xolcuay

- A rural setting - long distances between households.
- People farm the land and are hard to locate in their homes or have no time to talk.
- Indigenous groups – speaking a particular dialect, interpreters were needed.
- Male dominated – conflicts arose for some women participating in the project.
- Isolated – people are suspicious of outsiders, contact had to be made through village leaders.
- Few NGOs present in the area, clinics are remote.
- Partner organization: ECAP, national NGO working on psycho-social issues.
- Fieldworkers: one local female translator, two males from ECAP with university background.
- Socio-economic survey of 40 households.
- Diary studies for 6 weeks with 10 households.
- All are illiterate and the diaries were actualized by the fieldworkers.

- b) South Africa – Malelane, peri-urban area, Block A
- People speak different languages – field workers knowledgeable of various local languages needed.
 - Rampant unemployment – most people are easy to find at home.
 - HIV/AIDS is widespread – a disease not easily talked about.
 - Several clinics and NGOs present in the area.
 - Partner organization: Masisukomeni, local NGO working with women’s rights.
 - Field workers: two local females from Masisukomeni, one male with university background.
 - Socioeconomic survey of 40 households.
 - Diary studies for 6 weeks with 10 households.
 - Literate persons in all households, but they prefer talking over writing.
- c) Colombia – Cartagena City, the peri-urban slum area ‘Villa Hermosa’,
- Area of reception for internally displaced people from all regions of the country.
 - All speak Colombian Spanish, very few indigenous people present.
 - Rampant unemployment – most men work and most women are at home.
 - Several clinics, few NGOs in the area.
 - No partner organization.
 - Field workers: one female from the neighbourhood, one male with NGO background.
 - Socioeconomic survey of 80 households.
 - Diary studies for 8 weeks with 20 households.
 - Literate persons in all households, but they prefer talking over writing.

Appendix 3 - Significant life events (SLE)

Excerpt from SLE from South Africa.

| Year | Age | Migration History | | | R e N o | Family History | Personal Health | Employment | Violence | |
|------|-----|-----------------------|---------------|-----------------------------|--|--|-----------------------------------|-------------|--|---|
| | | Name of Place | Kind of Place | Events Pertaining to family | | History of Personal Health | Kind of Employment | F o n | Incidents of Violence Affecting Family | |
| 1973 | | Xai Xai in Mozambique | Rural area | X | Mother was a farmer | | | | | ? |
| 1979 | 6 | | | | Started school. School passed away. | | | | | Clashes in the family as to who was responsible for his upbringing. |
| 1981 | 8 | | | | Promoted to standard one | | | | | |
| 1983 | 10 | | | | | | | | | War came closer to the village in Xai Xai causing the family to live in fear. |
| 1985 | 13 | | | | Finished standard 4 but couldn't find a school to further up studies. | | Working at fields with the mother | X | | |
| 1987 | 14 | | | | Found a school to further up studies, classes interrupted by violence. | | | | | |
| 1988 | 15 | | | | | Had a big infection on the right foot. | | | | |
| 1990 | 17 | | | | | | Employed as a gardener | X | | |
| 1991 | 18 | | | | Moved to South Africa | | | | | |
| 1992 | 19 | Komatipoort | | | | | Farm employee | X | | |
| 1995 | 22 | | | | Found a job in another farm | | | | | Beaten up by the |