8

Participatory rural appraisal in identifying major illness, health care providers and costs

Sam Joseph

• Purpose

- To train a core group of Jamkhed workers in PRA methods, which they could later use for situational analysis in new, villages/new programme areas; and,
- To generate information on the status of health cares systems as part of a MHO (Maintenance of Health Organisation) proposal.

• Participants

- Comprehensive Rural Health Project: (CRHP) - Jamkhed. There were twelve participants (five from the CRHP Centre, 6 women health volunteers, 1 farmer's club member). Dr. Mrs. Arole also participated. Most of the team members have been working in the area for about 20 years.
- PACHEALTH (Pacific Health & Development Resources - Hawaii). Dr. Michael O'Byrne and Susan Cheney O'Byrne.
- ActionAid-India. Sam Joseph led the training.

• Duration

The PRA exercises and training were conducted over a five-day period – i.e. May 6 to May 11, 1991.
Questions to be answered:

- How many adults and children are there in the village?
- Which type of major illnesses has occurred in the last 6 months?
- What was the action taken to deal with these?
- How much did the treatment cost (including questions on how far did they go for medical treatment? To whom and why?)
- Who are the different types of health care providers and what are the reasons for using these health care providers?
- How much does it cost to access and use these different health care providers?
- Which diseases are considered important and why?

• Methods used

General

The group was divided into six teams. Those that were neo-literates were teamed up with literate persons. The first three days were scheduled for working in one village. The team would discuss specific methods in the class. These methods would then be attempted in the village. Some of the field exercises were conducted with 3 different focus groups of old men, young men and women. After each fieldwork session the teams would meet to present and discuss their diagrams and findings. The fourth day was scheduled for a new village in which the six teams would attempt the appraisal of the village in one day. The fifth day was kept for presenting the findings of the fourth day and further discussions.

Village-inside (social) and village-outside (resource) maps

Three teams attempted the mapping of the inside of the first village while three teams

Source: RRA Notes (1992), Issue 16, pp.53–56, IIED London

attempted the outside of this village. Each team covered a focus group of either old men, young men or women. At the end of the exercise the PRA group had maps drawn by village residents which showed differences in the perception of old men, young men and women, with regard to resources, roads, size of the village etc.

The next day, two of the teams which had done the village social map (village-inside) divided the village into 2 parts, and then each team with village persons marked out every house in the village. After this the names of the heads of households were listed by pointing to each house in the map and asking *"who is the head of this household"*.

On the third day both these teams, using the map as a focus point, asked village residents about major and minor illnesses. The process went something like this. After consulting the maps, a physical location was selected to sit and talk. Village persons were requested to call some people of the neighbourhood. When several people had assembled discussion followed along these lines:

Project staff would point to a house on the map/or read out a name of a household head. Then questions would be asked: How many adults in this house? How many children? Any children under 5 years? Do you remember any minor ailments in the past 3 months in this house? Did anyone get seriously ill during the last six months here? What did they do? How much did they spend? When the information about one house was complete then the discussion moved to another house.

One of the teams actually went to those houses which their group of informants had mentioned as having had major illness to cross-check. It was found that there were no major discrepancies between the account of the group and the concerned family.

Preference ranking / scoring

In the 'classroom' discussion session a mock exercise of preference on trees was carried out. First, trees were listed along with their major characteristics. Then a pair-wise comparison of each against all the others was done to elicit further indicators/characteristics. After this a grid was prepared with characteristics in the left margin and the trees across the top. A quick discussion followed about the benefits of ranking in terms of best/worst: dividing up 10 or 16 counters (seeds) across each row of characteristics; or awarding scores out of ten to each element in the grid. The group, especially the village level workers, felt that scoring out of ten for each element was most suitable. In the village, one team attempted a ranking of diseases while another team attempted a ranking of health care providers.

Seasonality diagrams

Two teams attempted seasonality diagrams on the occurrence of diseases.

Venn/chapatti diagrams

One team attempted the Chapatti diagrams to identify persons/groups which influence the village.

New village

In the evening of the fourth day a new village was selected and the following information was generated by the teams:

- A village map was completed with each house marked out with roads, water pumps, wells temples, etc. Names of each head of household were also noted. (A torch had to be used after dark).
- A village resource map with wells, ponds, check dams, was completed.
- A list of characteristics was identified for diseases in preparation for the ranking/scoring exercise.
- A preference ranking/scoring of health care providers was attempted.
- A seasonal analysis of the common diseases was attempted.
- In the morning of the next day (ie. fifth day), the teams completed the following:
- A transect of the village, which led to the identification of a major opportunity for

Source: RRA Notes (1992), Issue 16, pp.53–56, IIED London

repairing a check dam. Details of the resource map (village-outside) were also cross-checked.

- A chapatti/Venn diagram was constructed leading to the identification of individuals/groups who influence the village.

- A wealth ranking exercise was carried out with one informant, based on the list of household heads made by the social map team.

- A house-wise profile of the population; under-5 population; major illness and how they were treated; expenses involved; etc. was created using the village-inside map.

- A flow/process analysis was also attempted to define the steps taken when a person gets sick.

The entire group met again at the base to present and discuss their findings. The general feed-back from the group appeared to be that these methods were easier and faster than door-to-door surveys, which they had used earlier. These methods could be used in their existing project villages and also in a new project area now in the planning stage.

• New lessons learned

The **village-inside** map (or Social Map) is a very powerful tool. In addition to providing information on caste wise location, water resources, education, religious centres, etc. this map, after marking each home, can be used for generating information like base-line surveys on population, literacy, assets, etc. It can also be used to focus recall on issues like major illness and mortality.

If the village is large then different teams can select neighbourhoods, streets or castes to divide a large village into smaller units and then use the map to focus discussion.

Dr. Michael O'Byrne who came out to the villages on most exercises remarked that these methods of using diagrams and other methods to get into village people's mental maps and into people's `mental computers' were very powerful and it would not be long before the commercial world also start using these methods.

On reflection I agree with this, because most consumer surveys attempt to derive and infer usage patterns and preferences of consumers, using the producer's criteria, rather than the consumer's criteria, and that also in a restricted questionnaire format.

Regarding the **preference ranking**, the PRA team should not make any assumptions on characteristics of any topic. The 3 steps in the method i.e. first listing all diseases and their characteristics, secondly comparing them in pairs in terms of effect; and then finally starting the ranking, helped to bring out a large number of characteristics. In this PRA it was a local farmer who conducted all 3 steps of this exercise with other village residents as informants.

The findings of the **chapatti/venn diagram** provided an immediate list of key persons and groups who need to be contacted about proposals which affect the larger village. In this case where the project team want to begin a Health Maintenance Organisation, they plan to discuss the mechanism of contributions, health care delivery systems, etc. in separate meetings with individuals/groups, already identified in the chapatti /venn diagram. Later these issues will be discussed in open village level meetings.

In summary PRA methods can be used for generating information on health-related issues, especially in situations where there is clarity on the issues to be examined.

- **Sam Joseph,** Action Aid, PO Box 5406, 2 Rest House Road, Bangalore 560 001, India.

NOTE

A more detailed report of this work is available from Sam Joseph.

Source: RRA Notes (1992), Issue 16, pp.53–56, IIED London