

## **9. Applying RAP in Cape Verde, Africa and in poor areas of Rio de Janeiro, Brazil**

---

**By Clarice Novaes da Mota, Ph.D.**

*Clarice Novaes da Mota is an Adjunct Professor at the Instituto de Filosofia e Ciencias Sociais, Universidade Federal de Rio de Janeiro (UFRJ), Brazil and also a visiting scholar at the Department of Anthropology, University of California, Berkeley.*

**These descriptions of RAP in Cape Verde and Brazil were abstracted from a more comprehensive paper on the author's experiences with the methodology that was presented at the conference. A second abstract has been placed in the section on training in this volume for the sake of organization. This experiential analysis of the application of RAP to determine the impact of a programme for training traditional birth attendants in Cape Verde demonstrates the flexibility and practicality of the methodological approach when there are both time and language constraints. - Eds.**

MY MOST MEANINGFUL experience with the application of RAP was in a Portuguese-speaking African country, and not in Brazil. Apparently a contradiction, this fact illuminates the possibility of applying RAP even when it should be more difficult or awkward to proceed with a rather quick evaluation when the context is almost totally unknown to the investigator.

### **The Cape Verde experience**

RAP's pre-determined but flexible research structure proved to be extremely helpful in the planning and conduct of a rapid evaluation of Cape Verde, Africa. RAP allowed the researcher-evaluator to use a small sample to provide reliable and valid data. Cape Verde was a challenge: it was a new place for this researcher and the main language spoken was a mixture of African dialects and old Portuguese, with which I was unfamiliar. The study period was only three weeks during which the training of traditional birth attendants (TBAs), a programme organized by the Health Ministry and partially sponsored by UNICEF was to be evaluated.

#### ***The setting***

The Republic of Cape Verde is situated in West Africa and is composed of an archipelago of nine inhabited islands some 400 miles from West Africa. The islands are geographically divided into two groups - the northern (Barlavento) and the southern (Sotavento). We stayed in the Sotavento island of Santiago, where the national capital - the city of Praia - is located and where half of the nation's population lives.

#### ***The research***

The evaluation, done in February 1989, had two foci: to determine the impact of the TBA training programme on the target population and also to evaluate a training plan, determine the

number of TBAs trained and review training materials. The evaluation would review pre/post tests of TBAs, access knowledge gained, evaluate the supervisory system and, from the qualitative point of view, explain the fundamental sociological factors that permitted such activities to occur.

There was very little documentation on TBA activities. The UNICEF Plan of Operations 1986-1990 stated the objectives of the TBA programme as being two-fold: (1) to increase the coverage of trained TBAs to 100% for Santiago, and (2) to train 30% of all TBAs in the rest of the country by 1990.

Therefore, a selected number of TBAs was to be interviewed to determine knowledge and practices. An initial activity was to define the sample to include interviews with: (1) health personnel, mainly the ones responsible for the training, and (2) the women who had given birth attended by a trained TBA, and an untrained TBA, and at any hospital.

The work was divided into three main areas: the capital city of Praia, the interior around the village of Achada, and the other side of the island, a beach area known as Tarrafal. I was helped by two people in Praia: a male nurse, who trained the TBAs, and a female social worker. The latter proved to be more helpful because she did not have the drawback of being identified as a trainer. With her, the women relaxed and did not feel that they had to put in a good word for the training programme. In the interior, another male nurse accompanied my visits with local TBAs. A total of nine recycled TBAs on the island of Santiago, where 82 women had been retrained.

Using local interpreters, in-depth interviews were done based on guides for "health providers." The UNICEF medical doctor asked questions on medical aspects of the TBAs and health agents. I learned with her what to ask, and I suspect that she learned with me what to ask in other areas.

A difficult task was to interview the clients in hospitals and clinics, as there was no time left to go to their homes. I opted to interview them in waiting room situations and using the "exit interview." I was also able to do a focus group at the hospital in Praia with 12 women present and one nurse as the translator. In fact, all the rules for a focus group were broken at that meeting; it was actually a very formal gathering that ended up in an informal chat in two languages. I, the facilitator, missed a lot of what was going on because of the language barrier. But, the session did provide insight into the clients' perspective of health services, mainly associated with hospital births, that had not been acquired in other interviews. In this situation the clients appeared to feel "important" and that their opinions of services really mattered, thus they spoke freely of complaints, suggestions and problems that had not been clear before.

### ***Main research results***

It was found that most women still prefer home births with the assistance of a TBA over going to the hospital, even though Cape Verde's Health Ministry is working to give good, reliable assistance. The ministry's efforts to train birth attendants throughout the nation were apparent. It was recommended that a more rigorous programme of supervisory training of TBAs be carried on through development of adequate training criteria and goals. It was recommended that the older TBAs be encouraged to retire, because they are not able to adapt and use modern

techniques, materials and procedures. They were seen to be embedded in their "old ways" and did not see any strong reason to change.

The RAP guides were useful. They were helpful in organizing the work and the translated versions allowed my helpers to suggest terminology and actual questions that were culturally relevant but heretofore missing. The flexibility of RAP methods gave reason to believe that rapid assessment is indeed possible, even under duress.

## **RAPing in the periphery of Rio de Janeiro: Application of anthropological procedures to the assessment of programmes of nutrition and primary health care**

This paper also reports the experience of training and helping health agents to apply RAP in their programmes in Brazil. Such experiences have not only validated my own work as an anthropologist, but have also put me in the midst of what is really going on in terms of health and nutrition programmes.

The RAP guidelines [1] were partially applied in a semi-rural community known as Jardim Primavera (Spring Garden) in the outskirts of Rio de Janeiro city, in Brazil, during a period from August to November 1987 and April to July 1988, with the work of two anthropologists and an undergraduate student in social sciences.

The objectives of the investigation were to study the primary health care systems, to understand their rationale and functioning, perceiving the points of views of the health care providers and the users themselves, but focusing was on client/providers' relations and, consequently, the nature of health-seeking behaviour in the region.

Based on the RAP guidelines, a series of interview routines were planned in order to elicit information on income, number of residents in a household, children, sex, age, health needs, strategies for attaining health services, concepts about health and illness, belief systems and social networks, through open-ended questions. We were basically planning an ethnographic overview of community, focusing on the themes of health and healing.

Fieldwork was divided into three main tasks:

- Observation and interviews in the two health posts that serve lower to medium income families: two doctors, one laboratory technician, three nurse's aides, five users and two administrators were interviewed. Waiting room situations and medical consultations were observed. Similar procedures were applied regarding three folk healers - two women and a man. Pharmacists and the staff of the three local drugstores were interviewed as well.
- Observations and interviews in households with children under five years old: 15 families were interviewed, 10 of which were low income while the other five were lower-middle and middle class.

- Formal interviews with administrative personnel of the municipality, the Catholic Church, and community leaders.

### ***Research results***

**THE SETTING** Jardim Primavera (spring garden) lies within a network of small neighbourhoods belonging to the municipality of Duque de Caxias, in a district known as Campos Eliseos. Until recently these neighbourhoods were part of small farms such as the one from which Jardim Primavera inherited its name. Agricultural production declined immediately after World War II and the population increased at a rapid pace because of the heavy flux of migrants from Northeast Brazil, escaping the poor conditions of Brazilian rural life and a badly organized economic infrastructure.

Former rural workers in search of industrial and commercial jobs occupied, as squatters, most of the green areas of Campos Eliseos. The district now houses 27 slums, five of which are located in Spring Garden alone. Although these squatters' zones are not as crowded or sorry looking as the ones that burgeon on the hillsides of Rio de Janeiro city, they are characterized by very poor sanitary conditions and totally lacking sewage and drainage systems. Some houses are made of brick, or a combination of brick and wood, and are built at a certain distance from each other. With space becoming a scarce commodity, front and back yards are small, there are a few fruit trees and no vegetable gardens, with the exception of the larger households outside the poorer squatters' areas. However, most homes have a few medicinal herbs and trees.

In this peri-urban community, the lack of and/or the inefficiency of basic urban services is apparent. Transportation problems are dramatic. Because roads are unpaved, the heavy and continual traffic is in a constant state of calamity. When it rains, no matter how lightly, people have to wade through thick mud in order to cross most streets. Moreover, the city bus system is, for the most part, privately owned, and only a few buses service the whole area. Even to travel relatively short distances people have to take two or three buses and wait for long intervals between each. A direct trip to Rio de Janeiro is too expensive for most people, and they resort to crowded and poorly maintained trains that are always running off schedule.

These problems affect the health care delivery system, because people need mass transportation to reach the two low-income health clinics. Even for those who live within walking distance, it is not always easy to traverse the muddy, flooded streets.

During the study period in early 1988, heavy rains totally flooded Jardim Primavera and other parts of Duque de Caxias, destroying homes, and leaving the population isolated. People resorted to canoes in order to go through streets that had literally become rivers. Serious illnesses afflicted the population including diarrhoea, dehydration, high fevers, whooping cough and pneumonia. Medicines and oral rehydration solution packets were sent as gifts to the flood-stricken local population and the leader of one of the Neighbourhood Associations dispensed them from her house. Public health officers and governmental people had to resort to helicopters.<sup>1</sup>

**THE QUEST FOR HEALTH** The quest for health in the community was equated to the quest for food. A female informant put it very simply: "Our basic health problem here is lack of food."

Food, however, is a category that is not necessarily associated with "nutrition." Any food whatsoever is viewed as nutritious, with very little or no regard for content, such as vitamins, proteins, etc. Except for middle-class families, there is very little scientific knowledge about nutrition. "Food is food," said another woman, adding that, "whatever I can get my children will be good for them." To keep someone, especially a sick person, from eating one type of food rather than another struck most interviewees as irrelevant.

Food restrictions or food taboos were considered only in relation to certain categories of illnesses and in relation to herbal remedies that place them into "cold or hot" categories. Such categories exist throughout Latin America especially in lower income, indigenous areas<sup>2</sup> and for more than half of the interviewed families. "My children are perfectly healthy," was the assertion of mothers of children who had chronic earaches, puffed-up bellies, chronic running noses and coughing, as well as recurrent acute diarrhoea. Mothers tended to worry more - and therefore treat as "illnesses" - health problems like asthma, bronchitis, vomiting, and "nervousness"<sup>3</sup>.

In Brazil, except for communities that define themselves as ethnically apart - such as Indian tribal groups and some European-descent communities - and live in relative isolation, ethnic category is not as relevant as social class. To be Black in a slum does not carry any more stigma, nor is it any more indicative of a social phenomenon, than being White in a slum. The distinctive mark is living in the slum, i.e., belonging to the so-called lower classes. Moreover, there were no language barriers to serve as a distinctive mark of ethnicity. Therefore, all questions and observations dealing with the theme of ethnicity or language were excluded. That was a very clear point.

Even though the need for educational programmes became evident, and people agreed on this need, the infrastructural problems they faced seemed larger than the needs. They questioned the validity of educational programmes for people who worked a double shift, in the fields, in the factory and at home, with no spare time. Even if they had some spare time, some noted that it would be difficult to reach the places where such educational sessions could be held.

Answers to questions dealing with medication reflected an ambivalence that forced us to return several times to the same point, rephrasing questions and adding new ones. "Medicines" (*remedios*, in Portuguese) that came from industrialized pharmacies were still to be distinguished as allopathic or homeopathic, as homeopathy is popular in that region as well as in the city of Rio de Janeiro at large. In fact, one of the doctors at the Catholic sponsored clinic is a homeopathic doctor. These "medicines" are supplied through the market economy, i.e. they have to be bought. There are also the "home medicines" from gardens not mediated by cash and that belong to the exchange system of neighbourhood networks. One question that definitely had to be reworded and split into sections dealt with children's illnesses because, as already explained, the "most common illnesses" are not readily perceived as such in Brazil.<sup>3</sup>

Certain questions at first did not seem to make sense to mothers, such as "What can a woman do to have a healthy baby?" Women seemed puzzled by it, since no steps or precautions ever seemed necessary to have a "healthy baby." The concept of a "healthy baby" was thus shrouded in mystery, for any child who is able to survive only on breast milk and manioc flour with water has to be healthy. The concept of "health" is viewed as the lack of obvious or more serious

illness. A healthy mother is supposed to give birth to and raise a healthy child. A woman is considered healthy when she is fit to be on her feet in the early morning, doing her chores. An example of this was when an older lady appeared at the clinic with clear symptoms of TB. When asked why she had not come to the doctor before her condition became so serious, she answered that she had felt "fine" until then, although she had coughed a lot, because she was able to perform her household chores. Only when she felt so dizzy and weak that she could not stand on her feet was it suggested that she should see a doctor.

## **Endnotes**

1. The investigator and colleagues had to refrain from going to the area until the waters had receded and buses had started running again.
2. This idea rests on a conceptualization of diseases that ascribes illness to an imbalance of heat and cold in the body and holds that the restoration of health can be accomplished only through the restoration of the proper or 'normal' balances of these as 'hot' illnesses are treated with remedies defined as 'cold,' and vice versa. In Spring Garden this imbalance also involves "hot" and "cold" foods for some illnesses, mainly the ones perceived as directly related to the blood which can be "thin" = "weak" or "thick" = "too strong" = "hot." Starchy foods as well as certain specific herbs are given to people who need "tonics" for "thin blood."
3. Nervousness is a disease category that involves several symptoms such as lack of appetite, disturbed patterns of sleep (either sleepiness or insomnia), irritability, fatigue and lack of interest in just about anything.

## **References**

1. Scrimshaw SCM, Hurtado E. Rapid assessment procedures for nutrition and primary health care. Anthropological approaches to improving programme effectiveness. Los Angeles: UCLA Latin American Center, 1987.