

## **10. Application of rapid assessment procedures in the context of women's morbidity: Experiences of a non-government organization in India**

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**This paper describes the use of RAP by a non-governmental organization in India to obtain perceptions of slum women regarding health and illness and to obtain data for quantitative surveys and intervention strategies. In addition to ethnographic interviews with women it used cards representing illnesses that the mothers sorted into groups as a basis for further questioning. RAP was used to achieve a heightened awareness of the viewpoint of women: it showed personnel how to document their experiences, it contributed toward a realistic formulation of education messages, and it helped to improve intervention design. The principle difficulty was finding and retaining adequately trained personnel for ethnographic research. On the basis of this experience the researchers recommend RAP to other NGOs in developing countries. - Eds.**

MANY HEALTH AND nutrition programmes are introduced in communities before any culture-specific information has been obtained. Rapid assessment procedures (RAP) make possible the quick assessment of health beliefs and health-seeking behaviour involved in maintaining health and overcoming disease using modern as well as traditional health services [1]. RAP may also provide the framework for planning intervention programmes - the latter being a primary concern of most voluntary organizations. There is a need to document and understand the strengths and limitations of RAP as commonly used by voluntary organizations, especially in the context of health and nutrition.

The present paper describes the use of RAP by a non-governmental organization (NGO), Baroda Council in Baroda, India during the year 1989. The Council used ethnographic techniques with the following objectives:

1. To obtain traditional perceptions of slum women regarding their health, morbidity and patterns of treatment, with a focus on specific commonly experienced illnesses.
2. To obtain data useful for planning both quantitative data collection phase and intervention strategies.
3. To evaluate experiences of the Council in the application of RAP.

This paper focuses on the latter two objectives.

## **Methodology**

The present project is being implemented in two disadvantaged communities, slum A and slum G. having a total population of about 6,500. Muslim families are predominant in slum A (97%) and Hindu families are the majority in slum G (90%). Besides having the common denominators of poverty (average per capita monthly income Rs. 150 or US\$ 8), overcrowded and unhygienic living conditions, and low literacy levels of women (less than 50% female literacy), these two slums were purposively selected as to permit comparison of data between two different ethnic groups.

### **Sample selection**

Since the primary aim of RAP was to obtain folk perceptions of women's morbidity, women subjects were selected, so that:

1. they were likely to have experienced, or heard about, women's illnesses arising from marriage and motherhood;
2. they proportionally represented Hindu and Muslim families at different sites in the two slums.

Thus, married women, in the age group 20-50 years with at least one child, participated in:

1. Focus group discussions (19 discussions; average group size 15 women).
2. Free listing and pile sorting (60 women).
3. Ethnographic interviews (50 women).
4. Narratives (50 women).
5. Key informant interviews (2 indigenous practitioners and 4 Traditional Birth Attendants [TBAs]).

## **The ethnographic methods**

### *Focus group discussions*

#### **AIM**

1. To build rapport with women
2. To obtain the general framework of women's morbidity - types, etiology, treatment

#### **METHODOLOGY**

Initial focus groups were 'naturally forming' groups as curious women joined their neighbours who were discussing their health problems with the investigators. Later, the groups were systematized by selecting six to eight women per group: young mothers 20-30 years old or older women, 40+ years from a selected neighbourhood. The average size of the group, however,

invariably increased to 15-18 women. Each meeting was conducted by a pair of investigators: a facilitator and a recorder. The tape recorder was deliberately not used so as to allay the suspicions of women who, at that time, were unfamiliar with the project team. The tape recorder was used later to record individual interviews.

### ***Free listing and pile sorting***

#### **AIM**

1. To elicit information from subjects on the range of women's illnesses, including local terms used to describe each illness and associated symptoms.
2. To understand how women categorize different illnesses.

#### **METHODOLOGY**

Each woman was asked, in different ways, the names of illnesses common in their area and their associated symptoms. From the lists generated, frequently cited illnesses were pictorially represented on cards: one illness per card. The illness depicted on each card was explained and the women were asked to group the cards into piles (unconstrained pile sort). They were subsequently requested to explain the reasons for their grouping of illnesses. When women could not understand the concept of piles, the anchor-point clustering approach was used, i.e., women were asked to consider one card at a time and select other cards that went with the target card.

### ***Key informant interviews with the health providers, i.e., traditional birth attendants (TBAs) and indigenous medical practitioners***

#### **AIM**

To generate information about women's morbidity and health-seeking behaviour from health providers who have specialized knowledge about women's morbidity.

#### **METHODOLOGY**

Once the 'popular' local TBAs and indigenous practitioners were identified through general observations of the project team and information had been provided by knowledgeable women, these key informants were then contacted and informally interviewed using an ethnographic guide. Interviews were tape recorded and later transcribed.

### ***Ethnographic interviews with women***

#### **AIM**

1. To obtain background data on the socioeconomic and political structure of community families.
2. To obtain women's perceptions about 'female physiology': adolescence, pregnancy, lactation.
3. To elicit detailed information about women's health-seeking behaviour.

## **METHODOLOGY**

With the help of an ethnographic guide, each subject was contacted in her house and asked open-ended questions. Probing was minimal and non-judgmental; efforts were made to obtain unbiased responses. Responses were tape recorded and later developed into expanded field notes.

### *Narratives*

#### **AIM**

1. To obtain a step-by-step folk description of a recent illness episode.
2. To provide the range of health-seeking behaviors pertaining to specific, commonly encountered women's illnesses, i.e., malaria, anemia, leucorrhoea, menstrual disorders, infertility.

## **METHODOLOGY**

The above health disorders were selected on the basis of free lists, ethnographic interviews and the Council's health centre records. From these records, from among women who sought treatment within the past three months, 10 women for each disorder (total 50) were identified. These subjects were then asked to describe the illness episode: its symptoms, causes, treatment and home remedies.

### **Training**

The project personnel have received practical training in conducting ethnographic research through periodic workshops organised by the supporting agency, the Ford Foundation. Further, standard reference books and manuals [1-3] were followed to guide the data collection process. A protocol developed by the Johns Hopkins University for investigating women's reproductive health in India facilitated the application of the methods.

### **Results**

This section focuses on the strengths and limitations of each of the five ethnographic methods described above. The contribution of each method towards deciding intervention strategies is highlighted in Table 1.

#### *Focus group discussions*

Focus group discussions were of immense help in building rapport with women; in providing the framework for their health problems in general and reproductive health problems in particular. Through the process of group dynamics, i.e., women encouraging their neighbours to describe their problems freely, considerable data emerged on women's morbidity, on local terms used, and perceived etiologies and treatment patterns. An important outcome of focus group meetings was the setting up of a Health Centre for women in each slum, which was a felt need. "Open a health

centre for us and you will know all about our health problems" was a frequent comment from the women. *Limitation* of this method stemmed from the reluctance of women to impart certain information in a group setting, e.g., health problems carrying a social stigma (infertility) or treatment patterns resorted to privately (visits to traditional faith healer, "Bhagat/Bhuvas").

### ***Free listing and pile sorting***

Free listing elicited from women locally used terminology about their illnesses, which subsequently facilitated better communication with the respondents. Literate women responded more readily than illiterate ones. The majority of the illiterate women initially expressed ignorance about women's illnesses in their community, saying, "I am healthy ... I do not ask others about their problems..." However, to the question, "What illness makes you visit the doctor?" a list of a few illnesses was obtained, to which the women could subsequently add more.

Another difficulty encountered was the overlapping of 'illnesses' and 'symptoms.' An illness was often recognized only through its symptoms. Further probing in this case sometimes did not bring forth much new information, perhaps because the team shared the same cognitive understanding of symptoms as the women.

**Table 1. Application of RAP in Baroda Citizens Council - an Overview**

<b>Method</b>	<b>Purpose Served</b>	<b>Possible application of Information gained</b>	<b>Limitations</b>	<b>Comments</b>
<i>Focus groups</i> (90 minutes; for group of about 15 women)	Helped in building rapport with women	Helped locate in an informal manner" women leaders" who could help with project	Women would not talk about sensitive issues like infertility	Method useful in initial stages of project
	Helped decide interventions	Helped decide priorities for subsequent research		
	Provided data on terminologies used in morbidity by women			
<i>Free Sorting and Pile Sorting</i> (20 minutes for each)	Local description and categorization of disease symptoms obtained	Grouping of symptoms may help local doctors diagnose uncommunicative women	Women reluctant to talk about illnesses especially if they are currently healthy	Selected groups should target mothers 30+ years (likely to suffer morbidity)
	Pile sorting	Knowledge of local	Women reluctant	Skill required to

	(activity based) easier than free listing	terms helped workers communicate better with women	to explain piles (seemed to lack vocabulary to explain what they know)	probe without biasing responses
<i>Key Informant Interviews</i> (30 minutes for doctors, 45 minutes for TBAs)	Gave supportive data on women's morbidity; helped verify women's responses	Data may help in training TBAs	Doctors reluctant to reveal information about treatments prescribed (trade secrets)	Should invite participation from initial stages of project (local health workers)
	Provided insight into possible reasons why certain practitioners preferred by women		TBAs sometimes gave contradictory responses	
<i>Ethnographic</i> (45 minutes)	Provided cultural context of women's morbidity (i.e. family support, self esteem, etc.) Provided folk perceptions of female physiology, pregnancy, lactation, etc.	Data may help stress broader socio-economic issues as context for women's health care strategies	More time consuming than other methods hence practical problems of cooperation lower coverage, etc.	Combined with direct observations, insights gained on women's health attitudes and particular health seeking behaviours
Narratives (detailed descriptions of an illness episode; 2-3 one hour sessions)	Yielded illuminating and in depth data on specific illnesses (etiological factors, symptoms, types of treatment): The method's sharp focus allowed validation of responses	Data may be useful for patient education programmes; for modifying health care since women talk about expectations from health providers	Limited in scope as only women presently having illness gave meaningful responses; severity of illness affects responses.	Types of behaviour vary greatly according to age of duration of interview, etc.
			2-3 visits may be required for each illness episode	

Pile sorting helped determine the degree to which different signs and symptoms were perceived by women to cluster together those symptoms that they themselves (or family members) had

experienced, either simultaneously or one after another. Cause-effect relationships of illness - symptoms also emerged from the piles.

Examples:

Fever - headache - body ache;

Leucorrhoea - backache - weakness

Visual aids helped the illiterate women to identify the health disorders. Though pile sorting, because it was an activity, was easier to administer than other interview-based methods, considerable explaining was required to enable women to understand the concept of pile grouping. Difficulty was also experienced in eliciting from women the reasons for the pile groupings made, perhaps because the women 'knew' but lacked the vocabulary to express themselves.

It is envisaged that the grouping of symptoms may help local health practitioners and the Council doctors to diagnose health disorders in the female patients who often are shy and uncommunicative.

### ***Key informant interviews with health providers***

The traditional birth attendants (TBAs) or "dies" contributed information mainly related to dietary dos and don'ts during pregnancy and lactation and their method of conducting deliveries. With regard to women's morbidity, their responses were confused and uncertain; further, they usually referred sick women to doctors and limited their advice to simple home remedies. The local doctors, on the other hand, responded with clarity regarding etiology and symptoms of disease but were reluctant to elaborate on specific treatment prescribed, saying, "It depends on the individual cases."

Both groups of key informants corroborated certain information obtained from women; e.g., perceived etiology, treatment patterns, home remedies and attitudes towards health.

Limitations of these key informants arose chiefly from:

- variations and contradictions in response, especially regarding home remedies, amongst TBAs;
- the reluctance of doctors to spare time for the investigators and to share their specialized knowledge regarding treatment they prescribed.

### ***Ethnographic interviews***

These interviews provided the contextual family information that helped us to partly understand women's health-seeking behaviour, e.g., the busy household routine and presence of young children being real constraints to seeking treatment; inherent apathy of several women towards their own health; lack of any aspiration for themselves; indifferent family (husband) support, and so on.

The interviews also provided an insight into folk perceptions of female physiology: adolescent development, various organs in the body; pregnancy, lactation; preferences of women for home deliveries and hospital deliveries, etc.

The drawbacks of this method stemmed mainly from some of the abstract questions asked, which most women could not answer meaningfully. Examples: quality of life (past and present), concept of positive health. Further, women could not answer some questions simply because they had never given a thought to themselves - their bodies, their health.

Data from these interviews can help emphasize the need to integrate other developmental (e.g. education) and supportive (e.g., child care) programmes with health care services, which the present project is already attempting to do. Reasons for preferences of women for home deliveries and hospital deliveries will help the project team to design more convincing messages to promote hospital deliveries, which is feasible in an urban setting.

### *Narratives*

Narratives yielded illuminating data on specific illness episodes (leucorrhoea, menstrual disorders, infertility, malaria, anaemia): perceived etiology, progression of symptoms, sequence of health-seeking behaviour, preferred health practitioners, home remedies, constraints to seeking treatment, and other aspects. Narratives, by and large, confirmed the usual sequence of events known to health providers and, in addition, revealed interesting information on folk etiologies of disease (e.g., "excessive heat in body" causes disease), home remedies and nature of family support. Women's expectations from health providers regarding treatment and reasons for premature discontinuation of treatment were also highlighted.

Narratives, however, were very time-consuming (Table 1) and could be asked only of women currently undergoing treatment, as most women cured of an illness (despite its being recent) could not recall well the sequence of events or they denied ever having any illness.

This methodology can help design relevant patient education messages to overcome some perceived misconceptions about etiology and treatment of disease; it can enable medical practitioners to appreciate folk beliefs and the constraints of women seeking care.

### *Use of tape recorders in ethnographic interviews*

#### **ADVANTAGES**

1. Several significant pieces of information were available to us later that otherwise might have been missed.
2. The women felt quite important speaking into a recorder and their interest in answering questions was sustained.
3. The recorder facilitated a free flow of information between informant and investigator.

## DISADVANTAGES

1. Busy staff were overwhelmed by the large amount of time consumed in transcribing the taped information into expanded field notes. For an NGO, with limited manpower and several time and resource constraints, this might prove to be a real handicap.
2. In this project it is intended to use the recorder on a subsample as a check on the quality of data.

## Computer analysis of data

Generating reports through the computer became time-saving and meaningful *after*:

1. the field team learned the use of computers and personally fed the data into the computer;
2. the computer programmer spent a few weeks in the field meeting women and collecting data.

## Preliminary analysis of free listing and pile sort data

Table 2 represents the health disorders frequently mentioned by women through free listing; leucorrhoea, various menstrual disorders, fever weakness and aches/pains in body comprised the commonly cited morbidities. When informants were asked to clarify *excessive* menstruation and *scanty* menstruation, the response usually was in terms of days, i.e., 'excessive' and 'scanty' referred to menstrual periods over seven days and under three days, respectively. Occasionally, women compared their present cycle to that before marriage or birth of children. Similarly, leucorrhoea (excessive white discharge) or 'safed paani' as a health disorder meant discharge that was abnormal compared to their previous experience (usually the time period before and after deliveries) and was invariably accompanied by other symptoms like backache. Thus, whenever possible, women were asked to clarify the terms they used to represent illness/symptoms.

**Table 2. Free Lists of Women's Illnesses (N-60): The First Fifteen illnesses**

	Illness name	Local Term	
1.	Leucorrhoea	Safed Paani	70
2.	Back ache	Kumar dukhe	63
3.	Excessive Menstruation	Vadharre Masik	57
4.	Fever	Taav	50
5.	Headache	Mathu dukhe	57
6.	Weakness	Kamjori	43
7.	Pain in hands and legs	Hath peg dukhe	35
8.	Scanty Menstruation	Ochhu Masik	28
9.	Stomach ache	Pet dukhe	28

10.	Malaria	Malaria	20
11.	Irregular Menstruation	Aniyamit Masik	20
12.	Body ache	Sharir dukhe	20
13.	Cough	Khansi	18
14.	Problems during Menstruation	Masik wakhte taqlif	18
15.	Cold	Shardi	17

The pile sorts data in Table 3 reveal that certain illnesses were commonly grouped together, e.g., fever-headache (82%); fever-body ache (70%), scanty menstruation-stomach ache (53%), leucorrhoea-backache (42%).

The data showed the close association between fever and headache, weakness and excessive menstruation, with body ache appearing close by. These symptoms, backache-leucorrhoea formed one cluster; pain in hands and legs formed another. Scanty menstruation and stomach ache were less closely associated, while problems in the natal period stood separate. From the explanations provided by women, it appears that the grouping of symptoms was based on self experience or experience of a family member. When women were asked to explain the reasons for piling selected cards together, the reasoning process sometimes led to changing of the piles, in which case the final pile was chosen for analysis.

According to Weller and Romney [2], the results of pile sort methods, using samples between 30-40, generally reach reliabilities above 90 percent. In this case, the sample size was even more: 60. It is proposed to explore further the pile sort methodology using a greater number of cards (e.g., 25); 'multiple sort' using different criteria (e.g., age groups involved, severity etc.) each time end 'tried sort.'

## Discussion

**Table 3. Pile Sort Data: A Similarity Matrix of Women's Illnesses**

Illness Number	Percent Values										
	1	2	3	4	5	6	7	8	9	10	11
2	41.6										
3	38.3	6.7									
4	25.0	25.0	26.7								
5	5.0	8.3	16.7	30.0							
6	10.0	8.3	1.7	31.7	58.3						
7	8.3	5.0	0.0	30.0	70.0	1.7					
8	15.0	5.0	3.3	11.7	3.3	0.0	0.0	10.			
9	28.3	36.7	18.3	43.3	21.7	40.0	35.0	1.7			
10	5.0	3.3	11.7	3.3	3.3	1.7	1.7	0.0	8.3		

11	18.3	3.3	28.3	10.0	15.0	6.7	5.0	10.0	15.0	53.3	
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## Key

Illness#	Illness Name
1.	Backache
2.	Leucorrhoea
3.	Excessive Menstruation
4.	Weakness
5.	Body ache
6.	Headache
7.	Fever
8.	Problems during delivery
9.	Pain in hands - legs
10.	Scanty menstruation
11.	Stomach ache

In the context of women's morbidity, what did RAP achieve for the present project?

- RAP helped create a heightened awareness of, and an increased sensitivity to, the emic point of view, which NGOs operating in field conditions for several years are familiar with, but take for granted. Familiarity of the BCC personnel with the language, social organization and economic structure of the communities enabled them to cover the ground quickly as far as general ethnographic information was concerned, leaving them with more time to explore unknown territories - i.e., reproductive health problems. In contrast, in an inter-country dietary management of diarrhoea (DMD) project in Peru and Nigeria [4], difficulty was experienced in collecting adequate core data specifically for project needs in the time available, due to the necessity of obtaining general cultural information.
- Through emphasis on detailed documentation, RAP methodology trained the project personnel in regular documentation procedures and in recording their experiences. In contrast to academic or research personnel, whose strength lies in proper documentation, the experience of NGOs suggests that their focus on delivering services tends to result in neglect of proper recording of their experiences, i.e., impact evaluation gets precedence over process evaluation. The present project team believes that RAP has helped create a balance between the two.
- Documentation of the emic perspective is expected to contribute towards a realistic formulation of educational messages in the project's health and nutrition activities for women and adolescent girls. For example, an educational-cum-iron supplementation programme to reduce prevalence of anaemia in adolescent girls is under way, in which RAP methods lead to involvement of girls and their mothers right from the beginning, when they talk about their beliefs/practices pertaining to growth, development and health problems (anaemia) in adolescence.

Beyond the project, hard data from ethnographic research may help to make convincing recommendations to local government authorities to improve their health and nutrition programmes, particularly programme-related training of functionaries and education of beneficiaries.

Examples in the literature where anthropological and social marketing techniques have been employed to involve intended beneficiaries in improving their nutrition-related practices are the World Bank funded Indonesia Nutrition Development Project [5] and the DMD Project in Peru and Nigeria [6].

- Ethnographic research contributed towards intervention programmes. Like most NGOs, a primary concern of the Council is provision of need-based services to deprived communities. In this context, RAP served as the initial link in the chain of qualitative and quantitative data collection on women's health and provision of services. Services, in turn, made the data collection easier and more credible, especially in urban slums where the community was more exposed to data collectors and less often to service providers.

### ***Other uses of RAP***

In India, several NGOs are doing commendable work to improve the health status of needy urban and rural communities [7]. Thus, the anthropological approach may be applied meaningfully to promote:

- Street Hitkarini's female education programmes;
- Demystification of medicine through education as attempted by the Child-in-Need Institute;
- Attitudinal changes towards health as attempted by AWARE;
- The 'reach out to women' efforts of the rural health project;
- Experimentation of varied health communication techniques by the Comprehensive Health and Development Project at Pachod.

These examples highlight various possible applications of RAP methodologies for public health interventions by NGOs in India.

### ***Difficulties faced in the present project in the application of RAP***

- The high turnover of the Lady Medical Officer (LMO). Finding and retaining an adequately trained LMO for the project has been a difficult task. As a result, the uniformity and continuity of the qualitative research and provision of curative medical care are adversely affected.
- The organizational priority of the Council to provide services as well as the need to conduct ethnographic research often necessitated revision of time schedules to synchronize both.
- Certain difficulties were inherent in the RAP methods themselves and these were highlighted earlier.

## Recommendations

1. RAP needs to be applied in different settings in India: NGOs, government organizations, universities, and elsewhere. Bentley et al. [4] have also suggested that these methods should be further developed and tested under varying geographical and cultural conditions to establish their strengths and weaknesses.
2. Limited experience thus far suggests that RAP is best applied along with quantitative, epidemiological research, as each complements the other. In fact, the inter-disciplinary approach - for example, as recommended by Brown and Bentley [8] for improved nutritional therapy of diarrhoea should be more vigorously followed in public health programmes.
3. For developing countries in general, and for NGOs in particular, there is a need to develop, implement and evaluate intervention-linked RAP. Spradley [3] recommends that ethnographic research begin with informant-expressed needs. Social scientists can no longer ignore the uses to which research findings are put.
4. Finally, there is a dire need to build up a body of persons trained in ethnographic methodologies in the fields of medicine, nutrition, and allied disciplines. This training may be imparted either through modified university curricula or special training programmes.

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## 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.
2. Weller SC, Romney AK. Systematic data collection. Qualitative research methods Series 10. California: Sage Publications Inc., 1988.
3. Spradley JP. The ethnographic interview. Florida: Holt, Rinehart and Winston Inc., 1979.
4. Bentley ME, Pelto GH, Strauss WL, Adegebola O, de la Pena E, Oni G, Brown K, Huffman S. Rapid ethnographic assessment: applications in a diarrhoea management program. Soc. Sc. Med.; 1988; 27(i): 107-16.

5. Manoff International Corporation. Nutrition communication and behavioural change component, household evaluation (vol. IV). Indonesian nutrition development programme. Washington, DC: Manoff international Corporation, 1983.
6. Brown KH, Bentley ME. Report from Peru: Dietary management of diarrhoea. Mothers and children Bulletin on Infant Feeding and Maternal Nutrition; 1989; 7(3): 1-5.
7. The Ford Foundation. Anubhav: Experiences in community health. New Delhi: The Ford Foundation, 1988.
8. Brown KH, Bentley ME. Improved nutritional therapy of diarrhoea: A guide for planners and decision makers involved in CDD programs. Washington, DC: PRITECH, 1988.