

## **17. Rapid assessment procedures in the context of a rural water supply and sanitation programme**

---

**By Vijaya L. Shrestha**

*V.L. Shrestha is affiliated with the Rural Water Supply and Sanitation Project in Butwal, Nepal.*

**This paper describes the application of RAP to a rural water supply and sanitation programme in Nepal. This is a good example of the adaptability of the RAP approach since the author, V. J. Shrestha, is one of the original group of anthropologists that pioneered the RAP approach. RAP has proved useful because needed data are often nonexistent and conventional quantitative data collection methods are too expensive and time consuming. The author also affirms the relevance and sustainability of data on social dynamics that cannot be obtained through quantitative methods and states that RAP spontaneously elicited participatory development of the programme. - Eds.**

RAP WAS DEVELOPED as a methodology especially for health workers and social scientists in fields other than anthropology/sociology and to give anthropologists and sociologists guidelines for conducting rapid, reliable assessments of health seeking behaviour of people, including primary health care (PHC), nutrition and family planning, and maternal and child health (MCH) programmes.

RAP techniques are new phenomena in Nepal water supply and sanitation programmes. Their usage has been encouraged because the requisite data have been non-existent, conventional data collection methods are expensive, and field work for baseline surveys usually takes several months to do and twice as long to analyze. There is also a lack of data collection infrastructure and professionals to collect and analyze the data. Furthermore, our emphasis on a participatory approach, and on relevancy and sustainability of data on social dynamics and historical perspective cannot be obtained through quantitative methods.

RAP, in the context of the Lumbini Rural Water Supply and Sanitation Project, is a semi-structured process of learning with and from village people about their needs, problems/conditions, local resources, expertise, capabilities, experience and pertinent social information. This progresses into participatory planning, development and implementation of remedial activities that are relevant, acceptable, manageable and sustainable by the villagers. This process has led to a direct rapport that has stimulated activities not otherwise envisaged.

This paper discusses the applications of RAP to programmes of rural water supply and sanitation in Western Nepal. It describes the preparation for, and usage of, RAP in the planning and management of project activities and shows how these RAP findings strengthen and enrich water supply and sanitation public support programmes.

## **Project setting**

The Rural Water Supply and Sanitation Project (RWSSP) is a project funded by His Majesty's Government of Nepal and FINNIDA. The agreement between His Majesty's Government of Nepal and the Finnish International Development Agency (FINNIDA) was signed in November 1990.

The twin emphases of the Rural Water Supply and Sanitation Project are to: 1) ensure access to a safe and adequate water supply, and 2) promote health education and sanitation activities based on local realities, resources, and active beneficiary participation.

The projects include three major components involving both the provision of services and strengthening and upgrading of relevant government infrastructure, including beneficiary groups and institutions. The three major components are water supply; health education and sanitation; and training and research. Relevancy, continuity, and integration are the guiding principles for the planning and implementation of the project activities of the many facets of any water supply scheme. The two particularly difficult components are the promotion of participatory development and linking safe water with sound health in people's perceptions.

These principles can be translated into action through reliable and rapid assessment of needs; active participation of the beneficiaries in identification, and the development and implementation of the water and health schemes, including active involvement of the relevant mainstream government services (Drinking Water, Health and Educational Sectors) and indigenous institutions that are permanent and well established, located at the village/community and district level. In addition, the project has a variety of complementary activities. Community health volunteers are provided training in health, hygiene and sanitation. At the end of training, they are given a set of basic tools and medicines for first-aid treatment. The water users committee members are also provided with training designed to increase their perception of the benefits of safe water, better management, operation and maintenance of the community water supply system and improved health and sanitation practices. School teachers are trained to upgrade their health teachings and provisions are made to improve school sanitation environment.

## **Preparations for the uses of RAP**

A data collection guide was developed and from it an open-ended set of questions evolved (see Annex A).

To a large extent, utilization of data depends upon how they are presented and interpreted. When interpretation is complicated (technical, not easily understandable or isolated from planning needs) and the presentation is long and confusing, the findings are under-utilized and may be shelved. Hence, the second step in this study was to prepare formats for reporting information that would be directly relevant, precise and easy to understand (Annex B). The check list and report formats were pretested during the introductory training workshop on RAP methodology and revised after the workshop.

### ***Training workshop***

In the process of preparation, the third step was to prepare manpower who would develop skills and confidence in using RAP techniques. Overseers were the first group to be given intensive 10-day training in RAP during which they were required to go out to the village and apply various RAP data collection techniques, in particular observation, participant observation, informal dialogues, focus group discussions, personal interviews, walkabout surveys, and collection and use of secondary data, including recording and presentation of reports.

This exercise proved rewarding both for us and the trainees. It made the technicians/overseers realize the research is not necessarily a costly, time-consuming academic exercise, but that it could be a way to plan and develop the water supply and sanitation programme. Also, the trainees' interest and enthusiasm in the exercise continued with the wealth of information it brought in such a short period of time, and they were amazed to find things so different from what they otherwise had taken for granted. Two of the participant overseers had been in the same village where field work had been organized several times in connection with earlier water supply schemes, yet they had never been aware that the village community was so well organized or had well-established irrigation schemes, a client-patron system for agricultural and drinking water, village security, and so on.

Further analysis and application of these reports in programme planning were found to be very meaningful, as this brought the trainees closer to the people and gave them greater confidence in talking and working with them.

Social scientists and community-based health educators who had been trained in survey research methodology benefited greatly from a brief exposure to RAP techniques, especially its socio-ethnographic methods and focus group discussions. Their early training enabled them to understand and appreciate the usefulness of RAP methodologies, and they mastered the skill rather quickly. However, one-short training session for technical persons who are not social scientists is insufficient. Such persons usually need several practice training sessions under close supervision before they are able to master the skills necessary to apply RAP, and they must also possess the aptitude to teach.

### **Uses of RAP**

In the context of the rural water supply and sanitation programme, Rapid Assessment Procedures and techniques were adapted and developed specifically to assess the need for water supply schemes, prospects and possibilities for participatory planning, implementation strategies, relevancy, and appropriateness of health education and sanitation activities in a reliable, rapid way. Preliminary results from these assessments were available to the project within a period of two to 15 days. RAP was used at several stages of programme planning.

### **Situation study**

In the first stage, RAP was used to assess the needs for a drinking water scheme. Each village or

community that had requested a drinking water scheme was visited for a day or two, depending upon the size of the village. This was a Situation Study in which social scientists did a walk-about survey, made observations, and held brief informal dialogues with villagers individually and in groups in a random fashion to:

- learn the villagers' knowledge about the request;
- assess the conditions of drinking water facilities in terms of adequacy, distance, type, and quality; and
- obtain some information on villagers' previous cooperative efforts and experiences.

When it was found that villagers were aware of the need and eager for a sanitary water supply, a detailed sociocultural, economic and health feasibility was undertaken, again using RAP. This was usually done between four to 15 days after initial contact. This phase of RAP involved the prospective beneficiaries in several ways, i.e. focus group discussions, informal discussions, participant observation, data on village records, water sources, village experience in participatory development, and so on (see Annex B). The duration of this phase was again determined by the number and size of the villages to be covered. This process of data collection not only entailed in depth information on relevant software issues of water supply, but also made participatory planning natural and truly meaningful.

## **Planning**

After the feasibility study of the future course of action had been charted, the team and villagers gathered information on the health education, sanitation, and water supply scheme. A Water Users Committee was formed and community health volunteers were identified to train health workers and volunteers. The feasibility of additional sources of support and alternative courses of action was explored.

The use of RAP began with identification followed by detailed socioeconomic technical feasibility, followed by sharing our findings with the concerned villagers/beneficiary groups making them feel and act as true partners in planning a water supply and sanitation initiation programme with a sense of pride and confidence.

This encouraged open discussion between the project personnel and the villagers. As a result, such sticky problems as financial support using locally available materials and labour contribution, the location of tap stands or dugwells, formation of the Users' Committee and nomination of community health volunteers were all done by villagers, not by just a few village leaders or influential persons.

Likewise, information on health- and sanitation-related behaviour of the villagers and the sharing of this information in village meetings have been a tremendous help in making people understand the link between water and disease/illness. Knowledge of hygiene and health status has thereby increased interest and commitment in participation in village-based health education and sanitation activities. Within a period of twelve weeks and less, RAP enabled us to gather a wealth of information on health and sanitation behaviour, food habits, health and illness beliefs

and practices, and to provide training to a group of community health volunteers in the water supply scheme areas.

The use of Rapid Assessment Procedures has confirmed that, given the opportunity, acknowledgement of people and application of their skills, abilities and indigenous institutions and management systems will provide much greater ability to create, understand, and analyze the plans and situations. This not only creates rapport, but also paves the way for self-reliance, commitment and true partnership in development.

Finally, proper use of Rapid Assessment Procedures and techniques will help to demystify social science research in terms of cost, relevancy, timely availability and direct linkages with programme planning and management, and thereby make research an affordable and integral part of planning public assistance programmes.

## **Annex A: RAP guidelines for rural water supply and sanitation project evaluation in Nepal**

### *Situational Study*

#### **PROPOSES**

1. To assess the gravity of need for drinking water in terms of seasonal/year round scarcity; quantity available; time and distance (round trip) for collection of water.
2. To explore and understand village cohesiveness and past experiences and records of group/cooperative efforts.
3. To assess the awareness and extent of involvement of the proposed beneficiaries in making a request for water scheme.
4. Rapid appraisal of health conditions of the villagers, in particular children, in terms of common diseases and appearance.

#### **METHODOLOGY**

Walk about observation cum survey; mini focus group discussions; informal talks with change agents living in the proposed areas.

#### **CONTENT**

1. information on the present water sources,
  - distance/time used collecting water
  - quality of the water
  - system(s)

- condition/operational status
- rough population coverage

2. History and experience of community participation projects for water and other sector agencies

- their success and present condition
- what and how were the strategies, approaches adopted for community participation in the past projects?
- how successful or unsuccessful were these approaches and reasons for the same.

3. Who was involved in the making of the request? How are they involved? Are the different areas/wards and social/ethnic groups involved in filling the request?

4. What are the common diseases in the Village? What is the prevalence/occurrence in an average family?

5. Previous water projects?

- Agency?
- Community participation activities?
- The experience of the villagers about the implementation?
- Present status of operation and maintenance?
- Who is responsible?

***Feasibility study: Sociocultural, economic and, health***

**PURPOSES:**

1. To assess the feasibility of the proposed scheme
2. To establish sociocultural, economic, health and demographic data base
3. To record existing water usage practices and health and to enable appropriate sanitation related behaviour and HE programme, planning of the WS systems and sanitation.
4. To document rural social systems, community power structure and rural technology/technicians for planning the best suitable systems for management, operation or maintenance of the WS and sanitation systems.
5. To explore possible functional link with existing GO and NGOs activities

**METHODOLOGY:**

Basic socio-ethnographic methods will be used in the conduct of the above study. These methods permit detailed recording of the sociocultural context in which all kinds of rural behaviour and

practices occur in order to better understand and interpret the behaviour and the expected outcome of the activities to be introduced. The basic socio-ethnographic methods used will be Focus Group discussion, observation, participant observation, informal discussions and use of secondary data.

**DATA RECORDING METHODS:**

Field diary, files, village map

**DURATION:**

2-3 weeks (To be done before the implementation begins).

**PARTICIPANTS:**

Training officers/overseers/women workers (if feasible)

*Protocol*

Content	Data Collection Technique	Possible Source/s
<b>A. DEMOGRAPHIC CHARACTERISTICS</b>		
<i>Population Size Structure</i> by age, sex, social (caste/ ethnicity) groups, household size and growth rate, where possible	Secondary data	Health post
	Office records	Village
		Development
		Committee
<i>Social Characteristics</i> Type of household and settlement patterns(clustered or dispersed) by social groups/caste/ethnicity; educational level records	Observation	Village
	Informal discussions by social groups	key informats
		Office
		Schools
Settlement patterns in relation to existing water sources (if possible, a rough map showing the settlement pattern, existing and potential water sources). Also common land in the community, where taps and wells could possibly be located.		
<i>Economic Characteristics</i>		
<b>B. VILLAGE ECONOMY</b>		

<i>Sources of livelihood</i>	Focus Group	Village groups,
	Discussions	Village
<i>Which group do majority of people belong to?</i>	Appropriate groups, i.e. village leaders, villagers, men and women, various	committees
Farmers by type (share cropping, farming their own land, renting hired labourers, etc) size of land holding	change agents, villagers, extension workers	
<i>Village craftsmen</i>	observation	
<i>Seasonal work</i>		
<i>Unemployment in the village</i>		
<b>C. PHYSICAL CHARACTERISTICS</b>		
<i>Existing renewable natural resources</i>	observation,	Village
forest (private/public)	office	Forest
Water (river, springs, artisan) tree plantation by the water sources, quality and type of land landslides and erosion	documents	office
<b>D. HEALTH AND SANITATION BEHAVIOUR: Existing water sources and their use</b>		
<i>Survey of existing sources</i>	Survey	Village
<i>and their yield measured</i>	observation &	Villagers
<i>and conditions described.</i>	Water testing	villagers
Quality at present sources should be analyzed		Focus group
(Bacteriological tests)		Discussions
The following things should be studied during the feasibility study:		
<i>Existing water sources by use:</i>		
• drinking water		
• washing, bathing		
• cattle watering		
• their approximate yield, approximate number and distributions (geographical) of people using the source		
• approximate quality of source		
• average distance from the households using the source (time used collecting water)		
• times of the day when most people use the source		
• the condition of protective structure, if any		

- ownership and responsibility for maintenance. History of the source, who built it and when?

*Water use at household level*

Water carried <i>to home</i>		
• cooking, drinking	Focus group	village,
• washing, bathing (approx.	Discussions,	villagers
• animal watering amounts)	Observation,	village
	Participant health	
Water used <i>outside home</i>	Observation Workers	
• washing, bathing	Informal discussions	
• animal watering		Health Post with relevant person/s, office records
• industrial & handicraft use (building, brick making, etc.)		

Who in the household usually collects water?

*Health Behaviour*

Understanding of the link between water and diseases. Do people understand?

- polluted water at source
- connection of lack of sanitation and pollution
- spreading of diseases
- household hygiene

*Sanitation situation in the village and defecation behaviour*

- approximate number and type of latrines in the village
- institutions, schools, health posts, tea shops: do they have latrines?
- different groups (rich/poor/iternal, etc.) and their defecation behaviour
- different influential individuals VHW, school teacher, Family Planning Worker, and their sanitation situation practices?

<i>Cultural restrictions and practices</i>		
Special cultural restrictions/ beliefs/practices considering water use and defecation behaviour. In particular, are there some restrictions preventing village use of latrines, etc.	Focus group discussions,	Villagers of all walks of life, i.e., men, women, rich, poor literate, illiterate, priests, imams, health care practitioners, knowledgeable Brahmins, etc.
	Participant observation informal talks	
Castes using the same water point?		
Men/women working together?		
<i>Role and Status of Women</i>		
<i>Local laws, regulations, beliefs, and practices regarding water sources</i>		
<ul style="list-style-type: none"> <li>• ownership of the sources</li> <li>• common place for washing places etc.</li> </ul>		
<i>Presence or absence of Village Health Care</i>		
<ul style="list-style-type: none"> <li>• practitioners, traditional birth attendants, influential villagers in regard to health problems and services, care, and advice</li> </ul>		
<b>E. RURAL SOCIAL SYSTEMS</b>		
<i>Leadership structure</i>		
• formal influential leaders	informal talks	villagers
villagers influence	Participant observation	
<i>Decision-making procedures</i>		
Where are the decisions made and discussed:		
Meetings:		
Who participates?		
How often are they held?		
What is discussed?		
Chairman?		
Who initiates the meeting?		
How are people informed about the meeting? (chowkidar/katuwal)		

What area do they cover?

Indigenous organizations/institutions to regulate/manage village affairs i.e. social, cultural, economic, health and other social and political issues and problems (village chowkidar/katuwal, Guruwa, rural technicians and client patron relationships, etc.)

**F. EXISTING SERVICES AND FACILITIES**

*What are the present services in the village:*

• school	Observation	village and villagers, change agents
• health post/THCP	Focus group discussion	Village Development Committee
• administrative buildings		
• other projects of other sector agencies		
- agriculture		
- immunization		
- population control		

Transportation and Communication

Income generation projects - SFDP, PCRW, NGOs

Villagers' Concepts of Health, Illness, and Safe Water

1. Characteristics of a healthy person/child
2. Characteristics of illness
3. What makes one healthy/how to remain healthy?
4. What causes illness (fate, unhygienic practices, evil action, bad spirit, food ...)
5. Safe water is (appearance, taste, source, protection, container)
6. How to make water safe ...

Food Behaviour based on observation, interviews, and group discussion with villagers of all walks of life.

1. Hot food
2. Healthy food
3. Cold food
4. Infant food, frequency, reasons
5. Children's food, frequency, reason
6. Pregnant women:

a. Good food
b. Food avoided and why?
c. Food normally eaten
7. Lactating women:
a. Good food
b. Food avoided and why?
c. Food normally eaten

## **Annex A: RAP guidelines for rural water supply and sanitation project evaluation in Nepal**

### *Situational Study*

#### **PROPOSES**

1. To assess the gravity of need for drinking water in terms of seasonal/year round scarcity; quantity available; time and distance (round trip) for collection of water.
2. To explore and understand village cohesiveness and past experiences and records of group/cooperative efforts.
3. To assess the awareness and extent of involvement of the proposed beneficiaries in making a request for water scheme.
4. Rapid appraisal of health conditions of the villagers, in particular children, in terms of common diseases and appearance.

#### **METHODOLOGY**

Walk about observation cum survey; mini focus group discussions; informal talks with change agents living in the proposed areas.

#### **CONTENT**

1. information on the present water sources,
  - distance/time used collecting water
  - quality of the water

- system(s)
- condition/operational status
- rough population coverage

2. History and experience of community participation projects for water and other sector agencies

- their success and present condition
- what and how were the strategies, approaches adopted for community participation in the past projects?
- how successful or unsuccessful were these approaches and reasons for the same.

3. Who was involved in the making of the request? How are they involved? Are the different areas/wards and social/ethnic groups involved in filling the request?

4. What are the common diseases in the Village? What is the prevalence/occurrence in an average family?

5. Previous water projects?

- Agency?
- Community participation activities?
- The experience of the villagers about the implementation?
- Present status of operation and maintenance?
- Who is responsible?

***Feasibility study: Sociocultural, economic and, health***

**PURPOSES :**

1. To assess the feasibility of the proposed scheme
2. To establish sociocultural, economic, health and demographic data base
3. To record existing water usage practices and health and to enable appropriate sanitation related behaviour and HE programme, planning of the WS systems and sanitation.
4. To document rural social systems, community power structure and rural technology/technicians for planning the best suitable systems for management, operation or maintenance of the WS and sanitation systems.
5. To explore possible functional link with existing GO and NGOs activities

**METHODOLOGY:**

Basic socio-ethnographic methods will be used in the conduct of the above study. These methods permit detailed recording of the sociocultural context in which all kinds of rural behaviour and practices occur in order to better understand and interpret the behaviour and the expected outcome of the activities to be introduced. The basic socio-ethnographic methods used will be Focus Group discussion, observation, participant observation, informal discussions and use of secondary data.

**DATA RECORDING METHODS:**

Field diary, files, village map

**DURATION:**

2-3 weeks (To be done before the implementation begins).

**PARTICIPANTS:**

Training officers/overseers/women workers (if feasible)

*Protocol*

Content	Data Collection Technique	Possible Source/s
<b>A. DEMOGRAPHIC CHARACTERISTICS</b>		
<i>Population Size Structure</i> by age, sex, social (caste/ ethnicity) groups, household size and growth rate, where possible	Secondary data	Health post
	Office records	Village
		Development
		Committee
<i>Social Characteristics</i> Type of household and settlement patterns (clustered or dispersed) by social groups/caste/ethnicity; educational level records	Observation	Village
	Informal discussions by social groups	key informants
		Office
		Schools
Settlement patterns in relation to existing water sources (if possible, a rough map showing the settlement pattern, existing and potential water sources). Also common land in the community, where taps and wells could possibly be located.		

<i>Economic Characteristics</i>		
<b>B. VILLAGE ECONOMY</b>		
<i>Sources of livelihood</i>	Focus Group	Village groups,
	Discussions	Village
<i>Which group do majority of people belong to?</i>	Appropriate groups, i.e. village leaders, villagers, men and women, various	committees
Farmers by type (share cropping, farming their own land, renting hired labourers, etc) size of land holding	change agents, villagers, extension workers	
<i>Village craftsmen</i>	observation	
<i>Seasonal work</i>		
<i>Unemployment in the village</i>		
<b>C. PHYSICAL CHARACTERISTICS</b>		
<i>Existing renewable natural resources</i>	observation,	Village
forest (private/public)	office	Forest
Water (river, springs, artisan) tree plantation by the water sources, quality and type of land landslides and erosion	documents	office
<b>D. HEALTH AND SANITATION BEHAVIOUR: Existing water sources and their use</b>		
<i>Survey of existing sources</i>	Survey	Village
<i>and their yield measured</i>	observation &	Villagers
<i>and conditions described.</i>	Water testing	villagers
Quality at present sources should be analyzed		Focus group
(Bacteriological tests)		Discussions
The following things should be studied during the feasibility study:		
<i>Existing water sources by use:</i>		
• drinking water		
• washing, bathing		
• cattle watering		
• their approximate yield, approximate number and distributions (geographical) of people using the source		
• approximate quality of source		
• average distance from the households using the source (time used collecting water)		
• times of the day when most people use the source		

- the condition of protective structure, if any
- ownership and responsibility for maintenance. History of the source, who built it and when?

*Water use at household level*

Water carried <i>to home</i>		
• cooking, drinking	Focus group	village,
• washing, bathing (approx.	Discussions,	villagers
• animal watering amounts)	Observation,	village
	Participant health	
Water used <i>outside home</i>	Observation Workers	
• washing, bathing	Informal discussions	
• animal watering		Health Post with relevant person/s, office records
• industrial & handicraft use (building, brick making, etc.)		

Who in the household usually collects water?

*Health Behaviour*

Understanding of the link between water and diseases. Do people understand?

- polluted water at source
- connection of lack of sanitation and pollution
- spreading of diseases
- household hygiene

*Sanitation situation in the village and defecation behaviour*

- approximate number and type of latrines in the village
- institutions, schools, health posts, tea shops: do they have latrines?
- different groups (rich/poor/iternal, etc.) and their defecation behaviour
- different influential individuals VHW, school teacher, Family Planning Worker, and their sanitation situation practices?

<i>Cultural restrictions and practices</i>		
Special cultural restrictions/ beliefs/practices considering water use and defecation behaviour. In particular, are there some restrictions preventing village use of latrines, etc.	Focus group discussions,	Villagers of all walks of life, i.e., men, women, rich, poor literate, illiterate, priests, imams, health care practitioners, knowledgeable Brahmins, etc.
	Participant observation informal talks	
Castes using the same water point?		
Men/women working together?		
<i>Role and Status of Women</i>		
<i>Local laws, regulations, beliefs, and practices regarding water sources</i>		
<ul style="list-style-type: none"> <li>• ownership of the sources</li> <li>• common place for washing places etc.</li> </ul>		
<i>Presence or absence of Village Health Care</i>		
<ul style="list-style-type: none"> <li>• practitioners, traditional birth attendants, influential villagers in regard to health problems and services, care, and advice</li> </ul>		
<b>E. RURAL SOCIAL SYSTEMS</b>		
<i>Leadership structure</i>		
• formal influential leaders	informal talks	villagers
villagers influence	Participant observation	
<i>Decision-making procedures</i>		
Where are the decisions made and discussed:		
Meetings:		
Who participates?		
How often are they held?		
What is discussed?		
Chairman?		
Who initiates the meeting?		
How are people informed about the meeting? (chowkidar/katuwal)		

What area do they cover?

Indigenous organizations/institutions to regulate/manage village affairs i.e. social, cultural, economic, health and other social and political issues and problems (village chowkidar/katuwal, Guruwa, rural technicians and client patron relationships, etc.)

**F. EXISTING SERVICES AND FACILITIES**

*What are the present services in the village:*

• school	Observation	village and villagers, change agents
• health post/THCP	Focus group discussion	Village Development Committee
• administrative buildings		
• other projects of other sector agencies		
- agriculture		
- immunization		
- population control		

Transportation and Communication

Income generation projects - SFDP, PCRW, NGOs

Villagers' Concepts of Health, Illness, and Safe Water

1. Characteristics of a healthy person/child
2. Characteristics of illness
3. What makes one healthy/how to remain healthy?
4. What causes illness (fate, unhygienic practices, evil action, bad spirit, food ...)
5. Safe water is (appearance, taste, source, protection, container)
6. How to make water safe ...

Food Behaviour based on observation, interviews, and group discussion with villagers of all walks of life.

1. Hot food
2. Healthy food
3. Cold food
4. Infant food, frequency, reasons
5. Children's food, frequency, reason
6. Pregnant women:

a. Good food

b. Food avoided and why?

c. Food normally eaten

7. Lactating women:

a. Good food

b. Food avoided and why?

c. Food normally eaten