Introduction

THE INTERNATIONAL CONFERENCE on which this volume is based was held at the headquarters of the Pan American Health Organization, Washington D.C. in November 1990. Its purpose was to explore the use of anthropologically based methodologies for the design, evaluation, and improvement of programmers of nutrition and primary health care.

Improving human and social development during the 1990s poses a complex and daunting challenge nationally and internationally particularly to developing countries and emerging democracies. During the 1980s, child health and nutrition in many developing countries were significantly improved by adoption of policies promoting "child survival." Backed strongly by UNICEF, WHO, several bilateral agencies and international non-governmental organizations, national programmes of child survival focused on the primary health care services of growth monitoring, oral rehydration, breast-feeding, and immunization. Strong advocacy by many national and international leaders, effective mass media support and cross sector and non-governmental organization participation all supported "child survival" policies and one or more of the key interventions in several developing countries.

However, despite significant improvements in health services and in health education, national and donor emphasis on these specific programmers also brought widespread criticism. Debate continues on the "trade-off" effects of "strong vertical" programmes versus integrated primary health care services; on the sustainability and reach of services such as child immunization initially boosted by short-term national campaigns; on the impact of national and regional efforts to promote oral rehydration therapy, improved weaning and growth monitoring. There has also been much discussion in governments and in donor agencies on the appropriateness and long term effectiveness of designing strategies for national health and nutrition programmes that do not include significant participation by their major clients - the rural and urban poor.

Programmes for reducing diarrhoeal disease mortality through oral rehydration, despite significant positive results in campaigns to prevent dehydration and to teach home use of the method, do not prevent the disease. Just as important, behaviours related to environmental sanitation and personal hygiene must also receive emphasis if diarrhoeal disease is to be controlled. Improved water supplies and sanitary latrines may also be needed.

Growth monitoring programmes are being evaluated around the world in an effort to discover why some work well but most fail to influence maternal behaviour as intended. The aim is to develop more successful and sustainable programme strategies that will result in significant, long term health impact.

Breast-feeding promotions are now being reviewed and new strategies are being developed that will emphasize more strongly both preferred alternatives to early weaning and appropriate weaning practices once breast milk is no longer sufficient as the sole source of food. There is also a need to provide guidance for the growing number of urban mothers who work. Whole new

strategies are needed for countries such as those of the former Soviet Union in which breast-feeding often lacks even the support of physicians and nurses.

Nutrition-related problems, because they are often dependent on family resources, ingrained cultural practices, and complex commodity distribution issues remain difficult to overcome. However, with research clearly showing significant cognitive deficits, lost work potential, and increased susceptibility to infectious disease in persons deficient in micronutrients, "hidden hunger" has gained a broader platform with international donors. However, interventions needed to address the causes of "hidden hunger" are by no means sufficiently developed and, in many countries, even known solutions are often implemented slowly. Too often, the scale of nutrition interventions is too small to reduce the problem to a degree that significantly affects individual, social, and national development.

There is also growing recognition that chronic undernutrition forces a compensatory reduction in physical activity of both children and adults and has a wide range of other adverse consequences for individuals and populations. These include increased morbidity and mortality, reduced work capacity, poor reproductive performance, and impaired child development.

While the 1990s have thus far seen continuation of strong, national political will and international support for improving public health in developing countries, the issues are becoming more complex. The "Health for All by the Year 2000" goal implies continued efforts and support. However, national public health tasks ahead will be constrained by continued pressures of adjustment programmes that are likely to keep the national health budgets relatively small. In addition, newer problems such as AIDS and the chronic diseases among older persons are already demanding greater attention and resources.

At the 1990 Conference on "Health Research For Development" hosted by the Nobel Assembly,[1] UNICEF Executive Director James P. Grant noted the complexity and urgency of public health challenges in the 1990s could only be met with better information about and from the community, and more consistent use of such information to build and revise programme strategies. Better programme monitoring and evaluation are also essential both to achieve those national targets for child survival interventions that remain distant, and to reach the hardest to reach and under-served groups.

The papers on Rapid Assessment Procedures (RAP), Rapid Rural Appraisal (RRA) and related approaches[2] collected in this volume deal with research tools that offer strong potential both in public health and other areas. The tools described and discussed have significant conceptual and pragmatic contributions to make to the types of development programmes needed in the 1990s.

While origins of these approaches lie in the practical needs of programme planners and decision makers, their focus is often that of the rural and urban clients that development programmes should serve. These approaches investigate household and individual health-related behaviours within their complex, rational matrix of personal and social realities. They search for opinions and attitudes, behaviour, and motivations of both the clients of development programmes and also those who deliver services. Understanding both groups is essential both to planning and evaluating health, nutrition and other social development programmes.

The trained investigator uses these approaches to explore behaviour, attitudes, practices, and causal factors. They include careful observation, probing interviews, and focus group discussions. Other methods include a variety of highly participative activities whereby people score, diagram, map, sort cards, and use other simple but powerful tools to describe and often explain their current and past situation and environment. While not aiming at statistical generalizations to populations, these approaches provide a framework for data verification and analysis through an iterative process allowing correction and learning as the research progresses. With RRA/PRA control of some tools is given over to the client, reversing roles and generating a process of self analysis by decision makers and giving them and new insights on client capabilities to plan, lead, and manage development efforts.

When the sets of methods, tools and approaches of Rapid Assessment Procedures (RAP) and Rapid Rural Appraisal (RRA) developed and began to mature during the 1980s, RAP was most often used in programmes for child survival and development. Critical to efforts to plan basic strategies for child survival programme components was a need to know which actually worked in the field. Different from many other development efforts, child survival programmes aimed at national coverage and even "pilot" projects included definite follow-up plans and an outline of stages for expansion.

For such reasons, many programme managers and donors saw the needs both to measure the impact of health and nutrition interventions on behaviours and also to learn more clearly why various strategies succeeded or failed. Quantitative nutrition and health surveys, the usual methodology for attempting to evaluate the impact of interventions, are so costly, time-consuming, invasive and difficult to negotiate and manage that they were rarely attempted. Moreover, managers felt the need to investigate more deeply than the usual quantitative survey would allow. There was a need to be able to understand individual and social behaviours of beneficiaries, of workers within the organization responsible for service delivery, and often of managers who implemented the programme.

Similarly, a renewed emphasis by some groups in the 1980s on community participation in programme planning required new tools as well. These project planners were genuinely interested in learning a community"; own perceptions of its needs and in building programmes from the community's perspective. Child survival planning began with an intervention and often a strategic framework based on known data. However, in-depth knowledge of the community was needed to adapt and develop a strategy which would effectively deliver a service or achieve a desired behaviour change among the project's clients.

Planners and evaluators needed in-depth, unbiased information on the communities they served and on the health related behaviours of their clients. In response to such needs, a small group, made up mainly of anthropologists, in the early 1980s began adapting anthropological investigation methods into procedures and tools that could be applied in a relatively rapid manner. Based on direct observation, unstructured interviews, and focus group discussions, they aimed toward gathering in-depth community level information on health and nutrition related behaviour at the household level. Their initial goal was explanatory information on the success or failure of health and nutrition interventions.

The name first given by the researchers for this approach was simply "Field Guide for the Study of Health Seeking Behaviour at the Household Level" (FNB, 1984). By 1986 they realized that a more descriptive name was needed because uses of the methodology were expanding rapidly for a variety of health-related interventions. They selected "Rapid Assessment Procedures: Anthropological Approaches to the Evaluation and Improvement of Programmes of Nutrition and Primary Health Care." This provided the convenient acronym "RAP" that is now used generically for the various adaptations of the procedures to a wide variety of uses, both alone and in combination with other approaches.

Also in the 1980s another group, working mainly in rural India, began developing and testing highly participative methods by which community members could express complex information about their homes, environment, work, and lives. This group was also interested in the effect on researchers, decision makers, and community members themselves of using such tools. They began to find that the use of such tools improved both the community's ability to plan for themselves and decision makers' appreciation of the community's development related opinions, knowledge and skills. This work became known as "Rapid Rural Appraisal" (RRA) or Participatory Rural Appraisal (PRA).[3]

During the 1980s, the core groups developing each of these related methodologies found international sponsorship. RAP has had ongoing support from the United Nations University (UNU) Food and Nutrition Programme for Human and Social Development and UNICEF, with additional funding from the Ford Foundation, Plan International, the World Health Organisation (WHO), the World Bank and others. With such support, guidelines on RAP have been produced in five languages, along with a descriptive videotape, specialized guides on specific issues and a training manual.[4]

Development of RRA/PRA has, for the most part, been in India, with some PRA studies and training workshops in Africa. Development and diffusion of the RRA-PRA concept and methods have been led by several groups including MYRDA, an Indian NGO; the Sustainable Agriculture Programme at the International Institute for the Environment and Development in London; the Canadian International Development Research Centre (IDRC) and Action Aid in India.[5] There has been a steady flow of informal notes, articles, commentary and case studies on RRA and PRA for the past several years.

By the end of the 1980s, RAP had been cited as a principle methodology in over 100 studies and investigations. However, by no means had all of the studies citing the RAP methodology utilized tools outlined in the RAP guidelines. For some, it appeared that "RAP" simply referred to investigations done in a hurry; including many questionnaire-based, quantitatively analyzed sample surveys if they were designed to be conducted rapidly. For others, casual interviews and observations made during site visits by international consultants became labeled as "RAPs". If based solely on the use of the name in official reports and papers, "RAP" investigations have been done on every component of primary health care and several other development assistance areas including emergency operations, women's income generating activities, and adult literacy. Despite the relatively low level of contact between major developers of the two areas of methodologies and the significant differences in their orientation, several cases can be found where "RAP" and "RRA" have been used interchangeably.

By 1990, several international and national RAP training workshops based on the guidelines had been led by members of the original RAP group. Sizable numbers of RAP symposia, RAP seminars and RAP workshops had been held in countries throughout the developing world and by various groups, sponsored by international organizations ranging from World Bank and UNICEF to the World Food Programme, WHO and the International Development Research Centre (IDRC). However, quality control of training in the methodology had become difficult because of the proliferation of RAP use.

Based on the proliferation of RAP and RRA based studies, the demonstrated value of these approaches to development programmes, and the need to discuss critical issues such as quality control and training, the UNU proposed a major international conference on RAP in late 1989. With added support from UNICEF and Plan International, the conference on Rapid Assessment Methodologies for Planning and Evaluation of Health-Related Programmes was held 12-15 November 1990 at the headquarters in Washington, D.C. of the Pan American Health Organization, Regional Office for the Americas of the World Health Organization.

Many of the over 50 papers presented at the RAP conference have been edited or revised for publication in this volume. The choice was made by the editors to include a large number in order that the reader have available the breadth of use of RAP as well as an exposure to the varying depth and rigor with which these techniques are applied. The conference's principal contributors were staff from donor agencies and practitioners from developing countries. They displayed at the conference and in their papers a wide range of educational and professional backgrounds and styles from the highly referenced academic to the more anecdotal and experiential.

The reader of this volume is provided with the breadth of applications of RAP and RRA and insight into the core concepts on which they rest and the tools that are used. Several papers demonstrate the continued rapid evolvement of the tools that surround the core techniques and "rules" of RAT' and RRA. Sessions dealing with the origins and current state of RAP and RRA and with the range of application of the methodologies resulted in a variety not only of tools but of examples. Conference sessions and papers also focused on constraints to institutionalizing RAP and strategies for better diffusing these methods to national institutions and within the major international donor agencies.

Training issues raised throughout the conference were also the focus of one panel session which was summarized along with related discussions for this volume. Questions on how to expand training without RAP losing a minimum level of quality as well as the question of "who should be doing RAP" were not answered at the conference, but the IDRC, the UNU and other groups dealing with RRA/PRA have since begun actively pursuing these issues. The conference concluded with a panel devoted to issues of research communication including means of more effectively disseminating and fostering use of research results by decision makers and also by the clients of programmes in the rural and urban communities.

In addition to papers, panels and discussions originating at the 1990 RAP conference, the volume includes additional work which the editors deemed useful or necessary to provide a full spectrum of the current state of Rapid Assessment Procedures.

RAP may in the coming years become less a research methodology than a development evaluation and planning tool. To date it has been shown to be a tool whose power and usefulness are well recognized. It has also been misused with less rigorous approaches sometimes being inappropriately labeled RAP.

This volume aims toward increasing the understanding of RAP and RRA, both as tools of investigation and potentially as integrated components of the community development process itself. As RAP is better understood, proponents need to build a better defined and reasonably rigorous training plan. In this way RAP concepts and skills can be better learned by more social scientists, by health and nutrition project designers and managers, and by health workers at all levels including that of the community.

RAP and the better use of information gained through these approaches should improve programme policies and decisions, and as such strengthen the tool kit which is so badly needed to address the challenges of national and international development in the 1990s.

Endnotes

1. Note on organization of the volume: This volume has been organized basically along the lines of the conference agenda. Some papers presented at the conference were not used and several others which are included have been revised by the authors or the editors. A brief introduction to each section and to the individual papers was provided by the editors. Where deemed useful, edited comments made at presentation sessions have been included without attribution at the end of chapters.

A selection of edited comments organized by theme and with attribution is provided in Section VII and titled "Rapping on RAP." The conference summary and a list of speakers/participants has also been provided. Reference styles vary to some extent, holding to the styles adopted by individual authors. In several chapters tables and figures provided in original papers have been summarized.

References

1. James P. Grant, Executive Director, UNICEF, Keynote Address at the Nobel Assembly Conference on Health Research for Development, Stockholm, February 1990.

2. Several names are given to the approaches which are the focus of this volume. However, Rapid Assessment Procedures (RAP), and Rapid Rural Appraisal (RRA) were the most commonly used. The alternatives, distinctions, and in some cases confusion, of names and terms are described in several of the papers and comments contained herein.

3. Much more recent work in RRA has evolved, particularly in India, toward more overt efforts to orient, train and provide in-depth experience in village life to programme managers, officials and researchers. When this approach moves toward an investigatory process that is less directed

by outsiders and is one in which the goals of the investigation become jointly chosen by villagers and outsiders, the name "Participatory Rural Appraisal" (PRA) has been used.

4. As a result, RAP Guidelines have been produced in four languages, (English, Spanish, French, and Chinese), a training video was developed, groups have developed a training manual and specialized guides for RAP studies in Breastfeeding, Diarrhoeal Diseases, Acute Respiratory Infections, and for HIV/AIDS related behaviours. An international newsletter on RAP is also published with UNU assistance.

5. In addition to field studies, there have been several RRA/PRA workshops and an occasional series; comprehensive "RRA Notes" is available from the Sustainable Agriculture Programme, International Institute for Environment and Development (SAP/TIED), 3 Endsleigh St., London WC1H ODD, UK.