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Participatory rural appraisal in a women's health education project in Bangladesh

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· Background

The Women's Development Project (WDP) of CARE-Bangladesh is a health education project currently working in 441 Bangladeshi villages. WDP trains village women who have been nominated by their neighbours as local health educators. Women are proposed on the basis of their good relations with community members, leadership capabilities, enthusiasm, and availability of time. The volunteer community health workers are called *para* committee members, the word *para* meaning 'neighbourhood' in Bangla.

Once selected the women participate in intensive residential training held away from their villages. They attend two three-day sessions in the first year, sessions where they are introduced to the WDP interventions using participatory training techniques. Residential training is followed up and reinforced by fortnightly meetings held between WDP field staff and the *para* committee members.

Community health education sessions are held in each *para* on a monthly basis. Initially these are facilitated by CARE staff but from the second year on, the *para* committee members begin to conduct these sessions.

The *para* committees also take on responsibility for transmitting health messages to between five and 15 nearby households. They provide information on family planning, control of diarrhoeal disease, the importance of environmental and personal sanitation, the value of nutritious meals, and the importance of appropriate breast-feeding and weaning practices.

WDP works in each village for four years. By that time, the *para* committee members are well-known features of the community, and have a good deal of knowledge about basic health, nutrition and hygiene.

· Why do mapping?

We were prompted to use mapping methods, having attended a short workshop in Dhaka. It seemed to us that there were a number of ways in which the PRA methods could be useful in the WDP. Our initial idea had been to use mapping to enable *para* committee members to assess their achievements over a period of time, and plan their work for the future, but the exercise described below was really seen more as an opportunity to explore the range of possible applications of mapping.

The mapping took place on December 27, 1992 in Ghunikesar village, Delduar Thana, Tangail district (one month after the initial workshop). This village has been involved in WDP since July 1990. Therefore, the *para* committees had been working with WDP for 2½ years. Four project staff (two from Dhaka and two who work regularly with these villagers) participated in the exercise. Thirteen of the 15 *para* committee members attended, as well as two members of the savings and loan groups that WDP also works with in the village. The mapping took place in a large courtyard between two houses. Although almost all of the women could sign their names, only one was literate.

After everyone had introduced themselves, we told the women that we were would like them to draw a map of their village. To do so, the women formed into three *para* groups. We

Source: RRA Notes (1994), Issue 19, pp.70–74, IIED London

suggested they draw the map on the ground, using sticks and flour. The women began their maps quickly. Some asked what they should draw and we suggested they show all of the households[1] in the *para* and other landmarks. That was about all the guidance they needed.

Within 30 minutes each group had produced a map showing all the houses and landmarks (schools, latrines, tubewells, canals, roads, groves etc.). They stuck branches in the ground to indicate particular trees which serve as landmarks, and a flower in a small medicine container to indicate a flowering bush in someone's courtyard. As the map was created, the participants debated amongst themselves about the placement or existence of different features. Based on our prior knowledge of the village, we believe that the map was extremely accurate. All the maps were different (some showed houses as circles, others as squares) but each was very clear:

Some asked if they should show the people who live in the houses, and we suggested that this was a good idea. *Dal* (lentils) which we had brought along were used for this purpose, with each lentil representing one resident. Within 20 minutes, they had indicated men and women, children and adults. This is certainly the fastest way to gather demographic information in a village. We then asked women if they could identify their houses, which they did with red powder. They then identified with orange powder the houses they each worked with. This latter information was cross-checked and found to be accurate.

We then asked the women what they had done as *para* committee members, and they began listing the following:

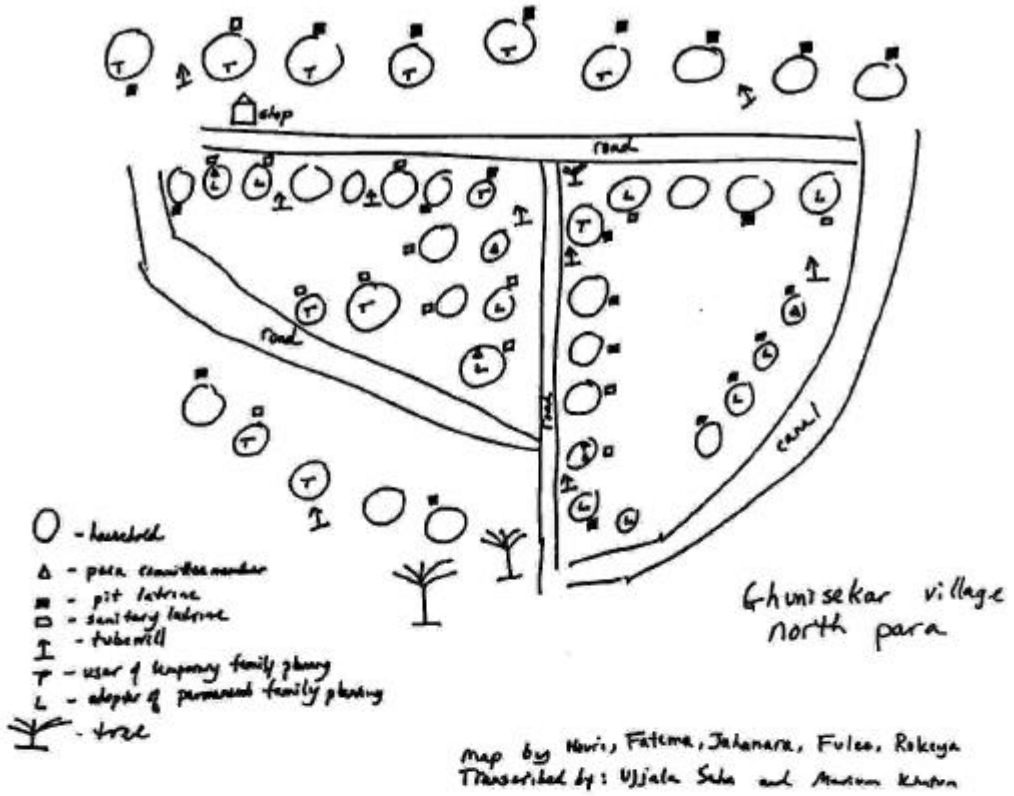
- promoting family planning;
- promoting litigations;
- promoting the installation of latrines;
- helping families understand the importance of nutritious food;
- promoting the use of colostrum for newborn babies;
- helping malnourished children become well-nourished; and,
- treating children with night-blindness.

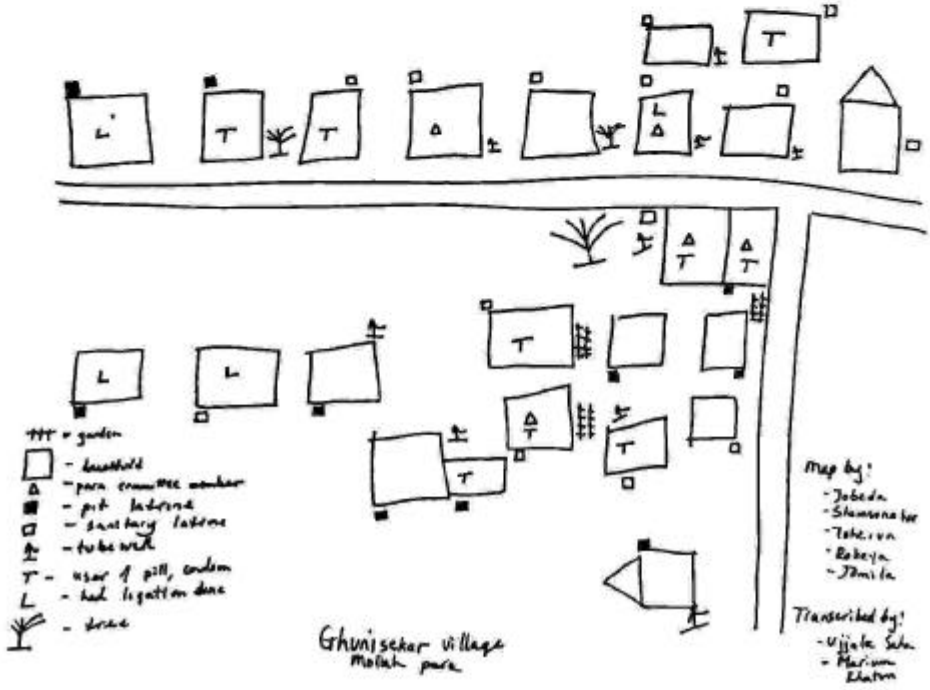
We suggested that they show these things on the map, and offered various types of *dal* and beans for them to use to indicate the households where they had been active. They indicated only those achievements they felt partly responsible for, excluding therefore, latrines that had been installed before WDP began working with the *para* committee members. We hadn't brought enough different types of beans, so we used material available at the site such as flower petals, leaves and bits of straw.

[1] The women understood amongst themselves that a household referred to a group of people using the same *chula* or stove.

Source: RRA Notes (1994), Issue 19, pp.70–74, IIED London

Figure 1. Maps transcribed onto paper





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When we asked the women if they wanted to show those households where mothers had been motivated to give colostrum, they said that all new mothers now did this, so they did not feel it was necessary to show this on the map. The two Tangail-based staff recorded each of the three maps on paper (See Figure 1). After they had finished their own maps, the participants took quite an active role in this, checking the accuracy of what had been recorded. Note that the maps done by the women were in fact much more elaborate than the paper versions shown here. It was important to transcribe the map quickly - after we'd sat down to discuss the experience, the chickens and dogs of the village started to eat up the flour and lentils.

The total time spent in mapping was two hours, followed by a discussion.

· Participants' perceptions

The women described the experience as very enjoyable. They obviously had a good time doing the map together, and felt both challenged and proud of their work. When one participant began to say that we (the outsiders) had taught them to do this, another interrupted her saying:

"No, they didn't teach us, we used our brain"

Although one or two older men looked on, they did not actively participate in the exercise, remaining observers. Most of the men were busy in the fields harvesting rice. The women liked the experience because the map offered a way to visualise their achievements as *para* committee members. Though they knew beforehand that they could draw the maps, they had never done so. They know that their work has had an impact - for example they cited the reduced incidence of diarrhoea in the village. However, they had never in this way depicted what they had accomplished in each of the houses, and for each intervention, and recognised that looking at the beans and leaves in each, they had achieved a lot. At the same time, they felt that by looking at the maps they could see the need in the future to put more emphasis on family planing. Visualising the situation on a house-to-house basis, they felt they could identify what is needed in each house.

· Future plans

The most immediate application of mapping appears to be the one mentioned by the participants: to enable *para* committee members to review their accomplishments and plan work for the future. Many of the project staff had felt that the women would not be able to create such maps. We ourselves have difficulty making maps of our neighbourhoods, and people were concerned that lack of literacy skills would pose a problem. Therefore the success of the exercise both shattered a myth they had held about *para* committee members and convinced them of the value of the process.

We are concerned about how we can extend the use of this mapping process to a large number of villages (we now have 441 villages and over 250 staff) while maintaining quality and flexibility in the process. Our initial plan is to continue to do demonstration exercises in each of the four areas where we work, taking two or three staff with us to observe and transcribe maps, and following the exercise with a discussion of the processes in the office with more of the field staff. We will develop guidelines, but they will probably focus more on the 'don'ts' than the 'dos'. Avoiding rigidity will be our biggest challenge.

Also, we need to explore how the very useful information generated during mapping sessions can be effectively communicated to management, while maintaining the flexibility of the process. Can we standardise the information collected without making the process mechanical?

· Applications for mapping in WDP

Potential uses of participatory mapping include:

- for CARE to select villages in which to work, based on a comparison of available resources and local problems/issues in a selection of villages;
- when WDP begins work in a village, identifying baseline health/economic status and identifying available resources;

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- determining coverage of the village population by service providers (traditional birth attendants, poultry vaccinator, family planning depot holders, *para* committee members);
- identifying linkages between traditional service providers ('quacks', other local doctors, clinics, government services) and *para* committee members and villagers;
- planning/objectives setting by *para* committee members early on in the project cycle;
- identifying and then ranking pertinent health problems/issues faced by villagers in order to prioritise those to be addressed;
- periodic evaluations/assessments by *para* committees of their accomplishments (as well as problems faced) leading into future planning/objectives setting i.e., the way in which the women used the information in this exercise; and,
- using information gathered in the graduation ceremony conducted when WDP leaves the village, i.e. outlining accomplishments of the *para* committee members (information could also be shared in other fora with community members and community leaders, possibly with government health workers too).

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