

Participatory methods for research on women's reproductive health

Report of a workshop in Karnataka, India

Elizabeth Tolley and Margaret E. Bentley

• Introduction

There are many examples of the use of participatory methods and techniques for agricultural research or community-based rural development programs. The use of PRA/RRA/RAP methods in health and nutrition, although much less in comparison, is at an exciting stage of development. There is a need for more application and documentation of the participatory methods for health-related programs and research.

In March 1992, the Johns Hopkins University School of Public Health (JHU) and the Ford Foundation/India (FF) sponsored a training workshop on the use of participatory approaches for women's reproductive health. The workshop was hosted by MYRADA, an India-based NGO that has pioneered the use of PRA methodology for rural development projects in India.

The participants of the workshop were individuals from NGOs and academic institutions that belong to an informal *women's health research network*, a project funded by the Ford Foundation in India and implemented by Johns Hopkins University (Bentley et al, forthcoming). The organisations are all involved in applied research for women's reproductive health. The project involves activities that assist the groups in the use of qualitative research methods for program development and evaluation. The project promotes systematic techniques and methods to 'listen and talk with women' and to include their voices in the design of program interventions for women's health. A key

objective is to provide community-based data that will influence program and policy decisions for women's health.

The *women's health research network* meets for regular training workshops and each group contributes to a quarterly newsletter, *Qualitative Research Methods*, which is edited and distributed by the Department of Health Services Studies, Tata Institute of Social Sciences (see *References*). Previous workshops have focused on the theoretical concepts of more formal qualitative research methods, such as ethnographic techniques, key informant interviews, focus group interviews, direct observation, systematic note-taking and analysis.

The objective of the workshop was to adapt some of the participatory methods developed within agriculture for conducting PRA exercises on women's health. With years of experience using PRA methods in their agro-forestry, irrigation, and rural development projects and with a solid record of training workshops, MYRADA was an excellent group to organise and host the workshop. The groups from the network brought vast experience in community-based health care service delivery and research, along with their recent experience in the use of qualitative research methods.

• Workshop design

The five-day workshop was conducted in a rural area of Karnataka, H.D. Kote, where MYRADA has a training centre. It was designed to achieve several goals. In keeping with its theme, the first goal was *participation*.

Workshop members 'learned by participating' in PRA exercises in a field setting. The participants were divided into four groups and several MYRADA staff members joined each group as translators. In addition to some informal classroom sessions, each group conducted one afternoon exercise with traditional birth attendants - *dais* - and two half-day field exercises in nearby villages. To encourage flexibility and creativity, the groups were given more and more freedom over the course of the workshop to design their own field exercises and activities. This allowed participants to pursue personal or organisational interests and encouraged experimentation.

An important goal of the workshop was to thoroughly document the experiences of the participating groups. After each field visit, groups were asked to write up the planning process and content of the activities and exercises, as well as any 'lessons learned' and to plan the activities for the next day's fieldwork.

- **PRA methods for health research**

Over the course of the workshop a number of participatory methods were tried. All four groups incorporated 'body mapping' into discussions with local *dais* (traditional birth attendants), and all worked on village mapping skills during visits to the field. In addition, some groups used transect walks, seasonality charts, venn diagrams, *dosa* or pie charts, timelines, histograms and other techniques to supplement their talks with local villagers. A description of some of the group experiences follows.

- **Body mapping**

We had received a draft document explaining how to do 'body mapping' by Andrea Cornwall, who adapted a technique for use in Zimbabwe that was earlier developed by Carol MacCormack for research in Jamaica (Cornwall, 1992). As Cornwall states, "*body mapping can be used to explore people's perceptions of a range of bodily processes and the effects of medical interventions in the body*" (4). We adapted the technique for our interactions with *dais* to explore their

perceptions of the reproductive tract, labour and delivery practices, and delivery complications.

At least two *dais* in each group worked together to draw the body maps, but in most groups the first drawings were conceptual, rather than physiological. This may have been because of the way questions were phrased or related to the *dais'* previous experiences with pictures and diagrams. One group had wanted to ask the women birth attendants to draw a picture of how they imagined the inside of a pregnant woman's body looked. Instead, the question asked by the translator was, "*How does the baby grow inside the mother?*". The question diverted attention from structures inside of the body and the position of the baby to an emphasis on uterine growth.

Foetal growth was represented in a similar manner by several *dais*. One group produced drawings of nine consecutive circles, each one slightly larger than the previous one. Another drew a long vertical rectangle with a horizontal line drawn across it about a quarter of the way from the top. This line, the drawer explained, was the pregnant woman's waist. A series of nine dots descended from just above the line to the bottom of the rectangle. In both sets of drawings the circles or dots were said to represent the monthly development of the foetus. The women explained that the baby was 'the size of a peanut' in the first and second month, the size of a lemon during the third month, an orange in month four and a coconut in month five. Some *dais* referred to these stages when describing other markers of foetal development. One group said the baby got 'life' or *jeeva* during four, while another said that this happened in month five. A different group reported that the baby 'kicked itself to turn around' with its head pointing downward in month nine. It was later learned that many of the *dais* had been taught this fruit analogy of foetal growth during a training workshop several years before. The trainer, who was present at the PRA workshop, explained that the concepts were based on traditional beliefs, which had been incorporated into her classes.

Some anatomically-related drawings were also done. This led to an interesting discussion of nutrition and contraception. The baby was shown in its own sac, separate but connected to the mother's stomach. When asked how the food eaten by the mother reached the baby, one

dai stated that there was a hole in the sac and food came in through the hole. Another disagreed, saying that *naramba* (translated as tube or nerve) connected the baby's sac to the mother's stomach. Food was conducted through this tube. Another *dai* continued that the food, upon reaching the sac, entered the baby through the soft spot, or fontanelle, in its head. Another referred to the diagram saying that there were a number of nerves or veins connecting the baby's sac to the stomach, and food reached the baby through them. She then said that if the woman had too many children, she could go to a doctor who would 'overturn' the sac. This would stop reproduction. If the nerves were cut (between the sac and stomach), this would also stop pregnancy. One of the other women added that it was important for the right nerve to be cut.

- **Village mapping**

One field visit was spent on village mapping. Participants found mapping to be both fun and useful. Villagers enjoyed the festive atmosphere created as they cleared away space for the map and gathered seeds, coloured powders and other materials. In most cases, the domination of a few individuals early in the mapping exercise gave way to much greater participation as the map progressed. As local people approached the map to verify that their houses were correctly located or to answer questions regarding certain households, they often remained standing to assist those who were drawing the map.

Individuals in the groups discovered that a great deal of information could be recorded on these maps traced on the ground. General census information was usually recorded first. This included the number of households and number of families in the village, as well as population statistics - numbers of adults and children, caste groups, education levels and types of employment. In addition, some of the maps revealed a wide array of health information. Villagers marked the houses of blind or handicapped persons, people with various illnesses and malnourished children. The houses of pregnant and lactating women were marked. Later, further information on pregnant women and the age of breast-feeding children was also recorded. For example, the location of pregnant and lactating women on a village map

led later to a construction of pregnancy time-lines detailing the types and quantities of food consumed during the various stages of pregnancy, as well as the amount of work women do while pregnant.

A group interested in food security issues located small holder farmers and landless labourers on their map and then asked the farmers to show cropping patterns and the amount of food available for local consumption over the various seasons.

One group collected information on family planning acceptors/non-acceptors and infertility. They also attempted to find out about abortion using the village map, but found this topic too sensitive to discuss in a large group. During this groups' exercise, some of the villagers did locate couples who did not or could not have children. Two 'infertile' men present during the exercise were brought forward. During a subsequent group discussion session, concern was raised that the mapping technique might not be appropriate for collecting very sensitive information. Group participants questioned whether the two infertile men might have felt ashamed by being identified and questioned in such a public way.

There was general consensus that the maps helped raise topics that could then be explored in more detail using other techniques. For example, after locating the local resources of health care on the map, one group asked villagers to list other health care alternatives and to indicate the importance of these resources and their physical distance from the community by drawing a Venn diagram. For general treatment, the Venn diagram showed that the government primary health centre, at a distance of five kilometres and costing Rs.1 on the bus, was commonly used for general medical treatment. This centre was much less important, however, for deliveries, when the local trained *dai* was called. Once the diagram was completed, workshop participants were surprised at the number of resources available and the complex factors that influenced the choice of one over another.

- **Comments**

The workshop revealed a number of ways in which PRA methods could be applied to

research and program development for health. However, most participants felt that when applied to research rather than for community motivation or project identification, certain considerations were vital. Triangulation, or the ability to quickly cross-check information obtained, should be an important aspect of PRA. This requires the researcher to understand which groups or individuals are participating, and whose 'voices' are not being heard. For a complete picture, representatives from different strata of a community must be present and actively participating. In addition, the information collected on a given day should be presented back to the community and further verified. During several of the mapping exercises, whole new sections of villages were added to maps on the second 'go'; and in one case the population of a village doubled after it was explained that the individual who gave the village population count was a local politician, interested only in the votes of adult villagers. He had left out all children under 18 years of age.

Participants felt that a successful PRA exercise required planning. Information should be elicited in a logical way, with general information first, followed by more detailed or sensitive information. Attention should be given to the way in which questions were asked, taking care not to introduce biases from the researcher's perspective. During the sessions with the *dais*, several groups asked about complications of child delivery.

Although none of the *dais* immediately listed excessive bleeding as a complication, almost all of the participant groups went on to ask if this was a problem. Perhaps because of time

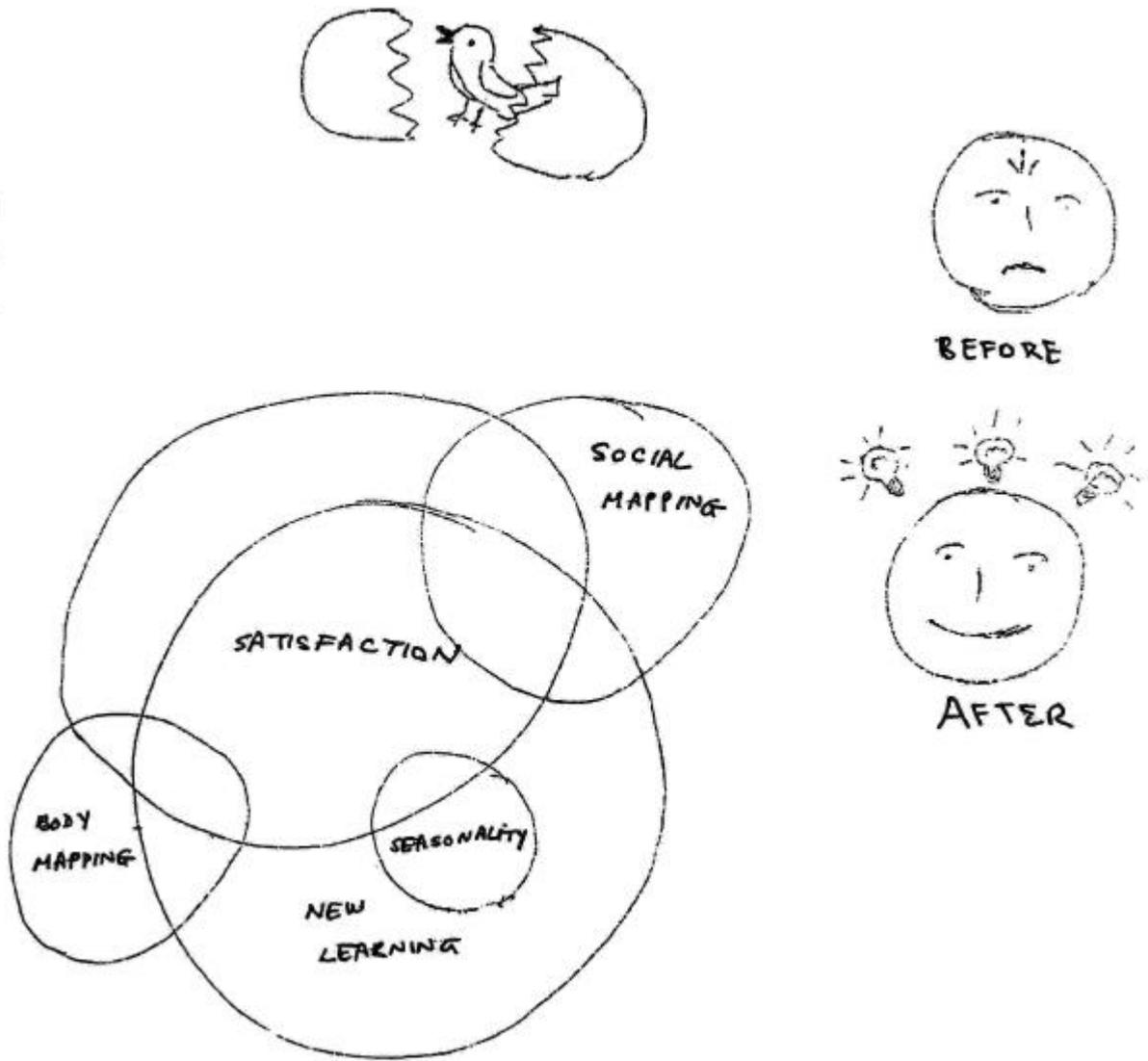
constraints or greater concentration on the process rather than the content of the activity, none of the groups, however, reached an understanding of how the *dais* defined 'excessive' bleeding - at what point bleeding was seen as abnormal and requiring some kind of intervention.

Good research - of any kind - should pay attention to the language and terms that people use. This may require special attention and a lot of extra note taking in PRA, where activity is often fast-paced and a number of people may answer questions or comment at once. If translators are needed, they should be included in planning sessions and be attentive to shades of meaning in the words, phrases or expressions that participants use.

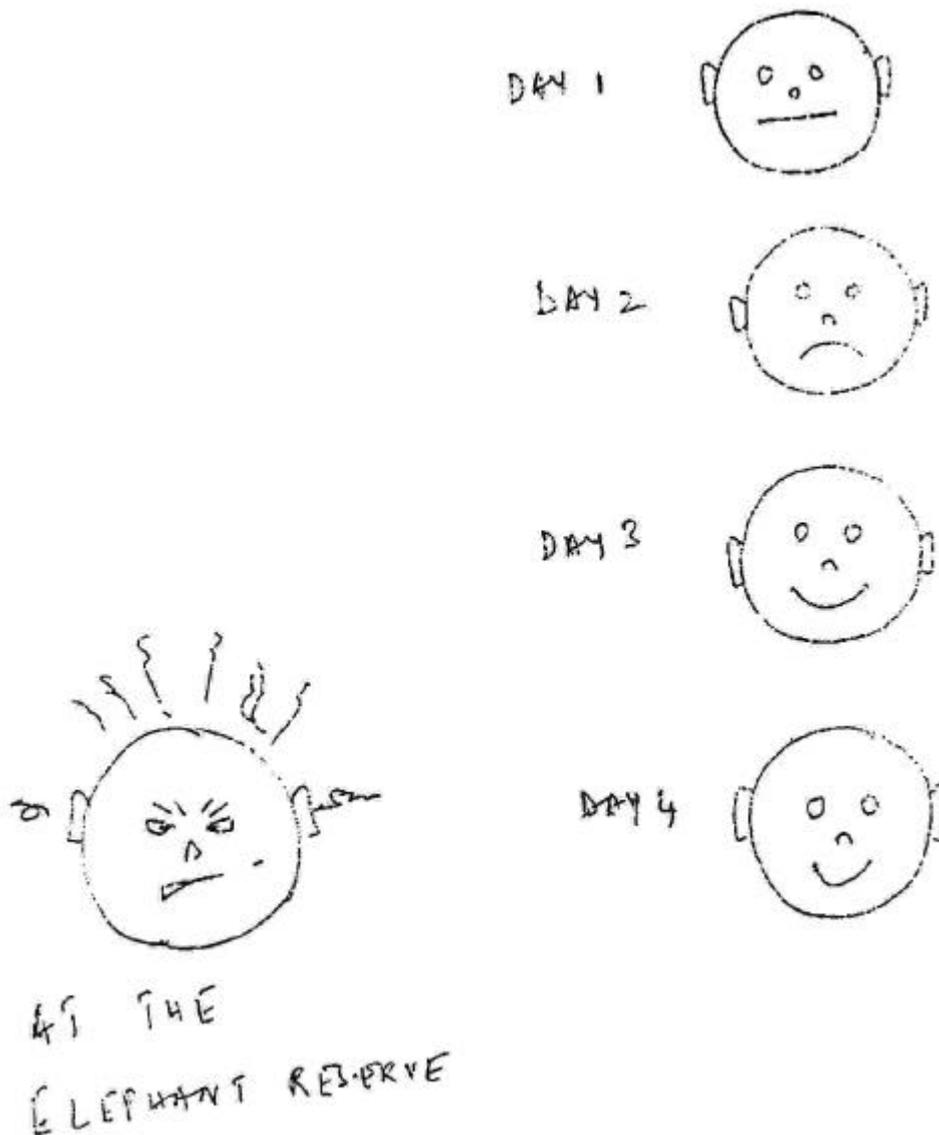
There will be a follow-up workshop in October 1992 of the network participants, hosted by the Institute of Health Management in Pachod, Maharashtra. Each of the NGO groups will report on the use of the new methods learned in their program development or research and how they plan to 'institutionalise' a more participatory approach in their work.

A longer report of the March workshop will be completed soon and will be available through Johns Hopkins University or the Ford Foundation/India. Until then, we leave you with a few of the pictorial evaluations that were done by the participants of the workshop - in keeping with one of the principles of participatory assessment, even completing an evaluation should have an element of fun!

7. Make a visual representation of our experience here over the last few days:



7. Make a visual representation of our experience here over the last few days:



- **Elizabeth Tolley**, Pushpa Milan, No. 12 Sophia College Lane, Bombay 400 026, India and **Margaret E. Bentley**, Johns Hopkins University, International Health, 615 N. Wolfe Street, Baltimore, Maryland 21205, USA.

REFERENCES

Bentley, M., Gittelsohn, J., Nag, M., Pelto, P., and Russ, J. (forthcoming). Use of qualitative research methodologies for women's reproductive health data in India. In: *Proceedings of the International Conference on Rapid Assessment Methodologies for Planning and Evaluation of Health*

Related Programmes, Pan American Health Organisation, Washington, DC., November 12-15, 1990.

Qualitative Research Methods Newsletter, Department of Health Services Studies, Tata Institute of Social Sciences, PO Box 8313, Deonar, Bombay, India.

Cornwall, Andrea. Body Mapping in Health RRA/PRA. In: *RRA Notes 16*. IIED, London, England.

MacCormack, C. 1985. Lay concepts affecting utilisation of family planning services in Jamaica. In: *Journal of Tropical Medicine and Hygiene* 88: 281-285.