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A note on the use of disease problem ranking with relation to socio-economic well-being: an example from Sierra Leone

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An RRA training exercise was conducted by ActionAid staff in a village in Kambia District, Sierra Leone in October 1991. The exercise was conducted with separate groups of old men, young men and women in the village. Female ActionAid staff worked with the women - who commented that they had never been consulted before. Male ActionAid staff, particularly the older ones, worked with the old men; and a second group of male ActionAid staff worked with the young men.

Four half-days were spent conducting intensive fieldwork with the community. On the second day of the fieldwork a well-being ranking exercise was carried out, which allowed us then to further sub-divide groups into better-off and worse-off members of the community.

On the final two days of fieldwork, with these smaller groups, ranking exercises such as sources of income, sources of credit, food preference and disease problem ranking were carried out. These exercises were most revealing, since they made it clear that the problems and solutions of the worse-off differed from those of the better-off in the community. It clearly illustrated how talking to the better-off older men alone, the normal practice of most development project staff, was *an entirely inadequate way* of gauging the complexity of a community's needs.

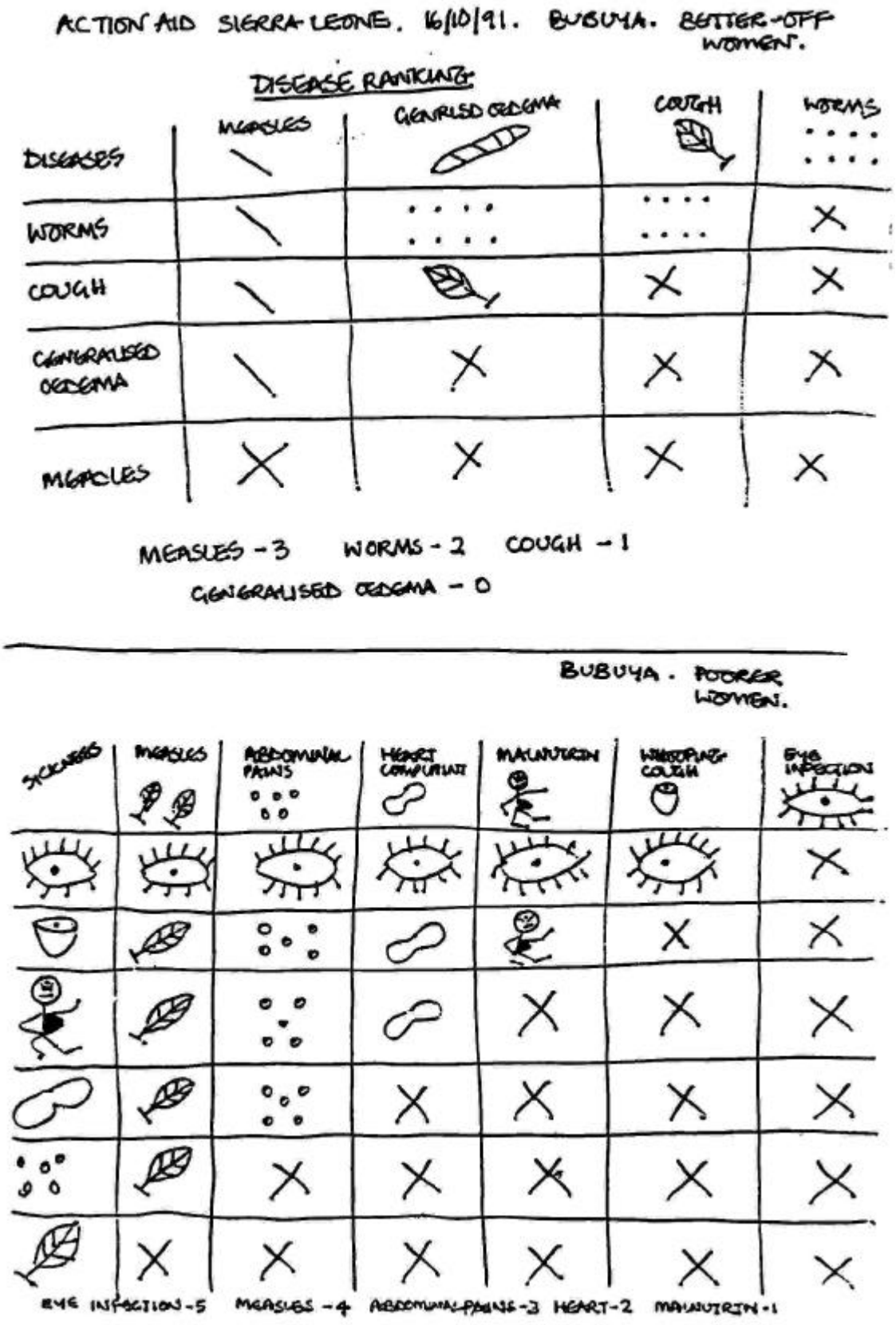
An especially graphic example of the differences was provided by the disease problem ranking of the women of the village. The two diagrams produced by the better-off and worse-off women are shown below (see Figure 1).

Whilst the better-off women mentioned four illnesses, with measles considered as the worst problem, the worse-off women interviewed in the same village mentioned six illnesses. These included eye infections which were also considered as their worst problem. Better-off women had not mentioned eye problems at all.

Such a diagram does not of course provide conclusive evidence of the connection between eye problems and poverty for these women. Nonetheless the findings of this exercise certainly warrant further investigation. Such tools of analysis provide an excellent starting point for 'interviewing the diagram', further discussion and exploration of health issues in relation to socio-economic conditions. These and other diagrams produced by the women in the village contained no writing initially and were entirely understandable to all concerned.

A final note of caution, however. One of the ActionAid staff members was a nurse by training. She had to be dissuaded from wearing her nurse's uniform on this exercise. But she still could not resist interpreting what the women described in her own professional terms: hence the mention of 'generalised oedema' on the diagram! It is strongly recommended that informants' own words for illness or disease be used in such diagrams, to avoid the immediate imposition of our own western concepts on their problems.

Source: RRA Notes (1992), Issue 16, pp.86–87, IIED London



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