

“*Mucoore* (trusted friend), let’s share with others!”



Developing radio and illustration materials for the Healthy Women Counselling Guide

Experiences from the Gender, Health and Communication Teams

UNDP/World Bank/WHO Special Programme for
Research and Training in Tropical Diseases (TDR)

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Dedicated to rural women

**“*Mucoore*
(trusted friend),
let’s share with others!”**

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Foreword

In May 1996, a meeting was held in Annecy, France, to discuss the early results of an experiment to develop stories and illustrations for the Healthy Women Counselling Guide (HWCG). Teams from the three countries - Kenya, Nigeria and Sierra Leone - which participated in the original research reported on in the booklet "Towards the Healthy Women Counselling Guide" presented their findings concerning the feasibility of the process, the steps taken and examples of the products that emerged. Radio tapes and illustrations on key gender and health issues, produced with the participation of rural women and men themselves, were presented to this international group, consisting of the Gender and Tropical Diseases Task Force and a selected number of experts on development-oriented radio and health communications.

The participants at the Annecy meeting were very excited about the results of this process and recommended that it be documented so that others could benefit from the experience. It was also recommended that the task be undertaken by the teams themselves, so that the richness of the different experiences could be captured and so that the teams would be able to share and compare their results in a more detailed and complete manner. A meeting hosted by the International Development Research Centre (IDRC) and funded by the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) was therefore organised for this purpose in Nairobi, Kenya, in August 1996.

This booklet is the product that emerged from the meeting, and documents the steps in the development of the Healthy Women Counselling Guide. It was written in 7 days and represents the combined efforts of a truly multidisciplinary, international team. In addition to the work of the authors, the tireless efforts of the facilitators at the meeting, Victoria Francis, Eva Rathgeber and Nicola Christofides, must also be recognised. Patience, dedication and sustained hard work were essential to the writing and completion of this document in such a short period of time.

TDR also wishes to thank the following donors, which contributed both substantively and financially to this process: the Royal Ministry of Foreign Affairs, Norway, the John and Mary MacArthur Foundation and the United Nations Drug Control Programme (UNDCP). The suggestions and active support of the Gender and Tropical Diseases Task Force, TDR, and the Gender and Health Research Group, WHO, are also gratefully acknowledged.

Carol Vlassoff 1997



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Sierra Leone Broadcasting Service (SLBS);
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Kenya Institute of Education, Educational Media Service;
Local Provincial Administration, Tunyai and Chiakariga locations, Kenya;
Research assistants who work in the various countries.

"Mucoore (trusted friend), let's share with others!" is the title chosen for this document because it reflects the idea, supported by qualitative studies, that many women rely on personal contacts and trusted female friends for information about their health. Such "trusted friends" can be seen as channels through which information can flow, and be believed and acted upon, since advice provided in this way often comes with practical support. What is needed is enough "trusted friends" to be in possession of accurate and practical information. It is also important to foster women's self-confidence and capacity to act positively for their health. In many cases this means understanding how gender relations affect women's health and limit their ability to seek proper treatment.



Chapter 1

Introduction

Background to the Gender and Health Research Activities

*Research Teams
from Sierra Leone,
Nigeria and Kenya*



Background research for the development of the Healthy Women Counselling Guide (HWCG) was conducted in three countries: Kenya, Nigeria and Sierra Leone. Qualitative research methods were used, including focus group discussions, in-depth interviews, group discussions, narratives, case studies and informal interviews. These provided in-depth information on the nature and extent of health and gender problems affecting rural women, as well as the various ways in which they respond to them. Ideas and suggestions to improve women's health included community-based and gender-sensitive approaches. The results of these studies are available in more detail in the accompanying booklet "Towards the Healthy Women Counselling Guide".

The research demonstrated that both women and men would like to learn about their own health and health problems. The idea of improving women's access to health-related information was approved by all community members. Women and others in the community had been

exposed to several channels of communication on health matters, including radio, films, village meetings, songs, drama, posters and health talks by professional health workers. It was decided to focus on two main communications strategies for the further development of the HWCG: stories produced as radio programmes and audiotapes, and illustrated materials.

Why this project?

The three research projects in Kenya, Nigeria and Sierra Leone documented the very low status of the women in the study communities, with women being valued mainly in terms of their procreative and productive roles. Discrimination against females was found to start from birth and continue throughout their lives. The overall goal of the project is therefore to encourage women to value themselves, to make informed decisions about their health and that of their families and, ultimately, to improve the quality of their lives.

The Healthy Women Counselling Guide will use radio/audio cassettes and illustrated materials to provide information and stimulate awareness of health and gender issues within the context of rural women's daily lives. It aims to develop materials which can be used in a public forum or as private reference to learn about health and correct treatment in times of illness so that delays in obtaining appropriate care are minimised.

About this booklet

This booklet documents the process involved in the development of the HWCG, taking "Towards the Healthy Women Counselling Guide" as the point of departure. It is therefore meant to complement "Towards the Healthy Women Counselling Guide" and to build upon its findings. **Chapter 2** describes the process itself, including the building of the communications team, identifying health and gender issues, involving the community and pre-testing. **Chapter 3** describes the development of the story line for the radio programmes in the three countries, and **Chapter 4** focuses on the development of illustrations to accompany the radio programmes. The **concluding chapter** draws out positive and negative lessons from the process and suggests future steps.

This booklet is meant for those who wish to participate in this or similar processes, including community development workers, researchers working on gender and health issues, non-governmental organisations (NGOs) working on women's health and development, and policy makers. It will also support and complement local efforts to generate relevant gender and health communication materials.

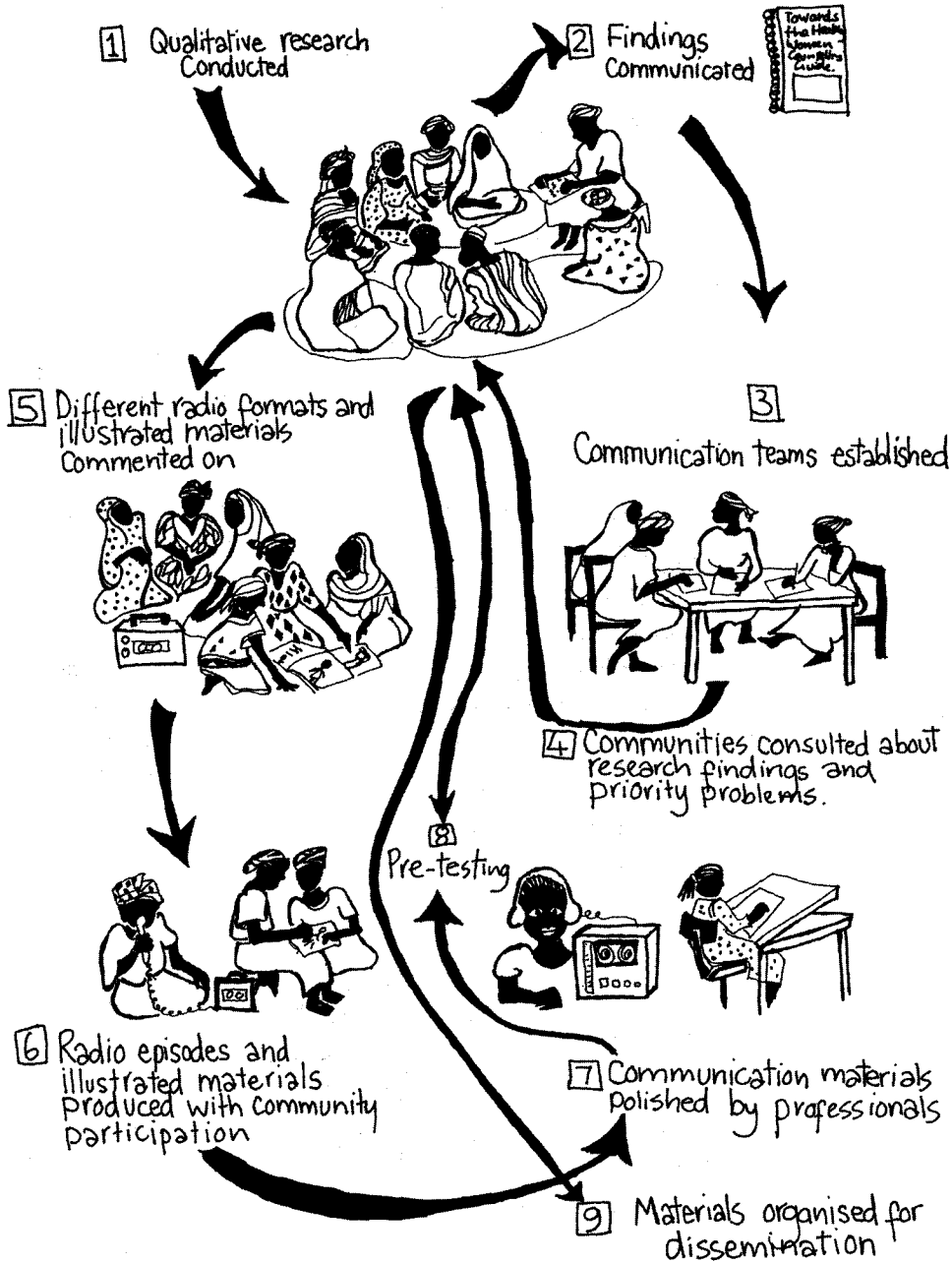
It could be used as a background document for policy meetings, health communication planning and training workshops:

- to provide examples of how community input produces rich material and demonstrates how social circumstances are interwoven with health;
- to stimulate health educators, radio producers and illustrators to develop gender-sensitive approaches and materials;
- to raise discussion about new approaches amongst policy makers who are influential in areas of health, materials production and the media.

The examples provided should be adapted imaginatively. For example, it might not be possible in certain contexts to produce or use radio or audio cassettes. However, it may be possible to adapt the core idea of engaging communities in developing a dramatised story using other media such as village theatre.



Summary of Healthy Women Counselling Guide Activities



Chapter 2

The Process

Following the earlier studies, the research teams were faced with the question, how should the research findings be used to develop communication materials for rural women?

The studies highlighted the inequality in gender power relations which compounds women's health problems and affects their health-seeking behaviour. These issues have been inadequately reflected in many health education approaches. It was clear that the HWCG should go beyond traditional information transfer and persuasive intent, and reflect the social realities of women. The findings from the research therefore provided the starting point for locating health problems within a social context. Furthermore, they pointed to the importance of maintaining the direct participation of community groups in the development of the materials. Continuous dialogue with end-users of materials ensures that situations presented are consistent with their reality, information is relevant and suggestions for healthy actions are achievable.

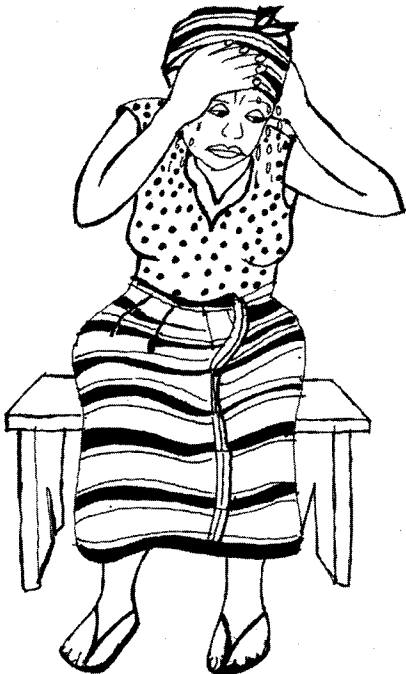
The studies identified a wide range of problems confronting women in the three countries. It was not possible in this pilot exercise to develop communication materials for all of these, so priority problems were selected. These include malaria, reproductive health issues such as sexually transmitted diseases including HIV/AIDS, vesico-vaginal fistulae (VVF), and pregnancy and antenatal care.

Identify gender issues

Using findings from the earlier research, the selected health issues were analysed in terms of underlying gender concerns which affect women's health and health-seeking behaviour. These are summarised in the following illustrations and text.

Malaria: “*Small insects, big trouble*”

- Women often tolerate symptoms of malaria until they are critically ill because of the perception that a sick woman is lazy or mean.
- Men are not always aware of women's health needs.
- Women lack resources to seek treatment and the power to demand appropriate services.
- Maintaining a healthy household and community is seen as a woman's responsibility, but women are often not included in village health committees.
- Women are reproached when there are malaria epidemics for having failed as custodians of health.
- Malaria is more common and more severe in pregnant women and children.
- In pregnant women malaria can cause anaemia, miscarriage and low birth weight babies.
- Women need information to help them recognise the symptoms of malaria in themselves and family members, e.g. fever, chills, headache.



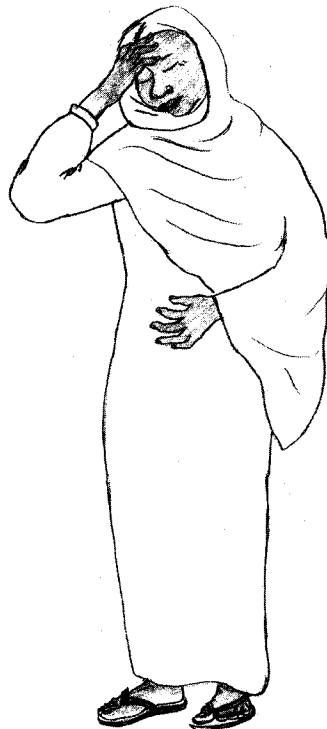


Pregnancy: “No baby, no marriage”

- A woman's status and security in the family depend on the number of children, especially male children, she is able to produce.
- Repeated pregnancies are a risk to women's health.
- Some women need permission from husbands before they can go to hospital for antenatal care and delivery, even in life-threatening emergencies.
- Many women are powerless to take decisions regarding their reproductive health and use of contraceptives.

Sexually transmitted diseases (STDs): “When he says open I open, when he says close I close”

- STDs are often referred to as a “woman's disease”, and women are blamed for being its source.
- Women are reluctant to discuss STDs: some believe they are a punishment from God.
- The shame and stigma attached to the disease prevents women from seeking prompt and effective treatment.
- Many women have difficulty negotiating safe sex with their husbands who visit commercial sex workers.



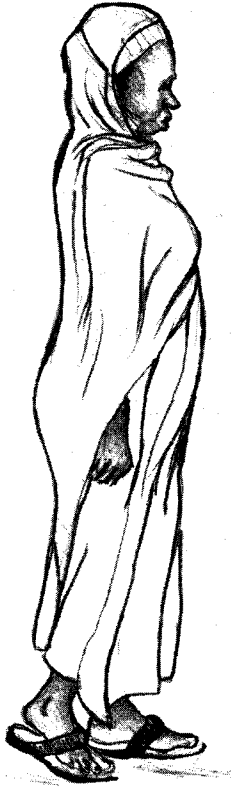
Early marriage and vesico-vaginal fistulae (VVF): “*Babies having babies*”



- Limited access to education, nutrition and economic resources for girls encourage early marriage.
- Men make the decisions regarding when and to whom their daughters will marry.
- In some communities women are valued for their procreative function and are, therefore, initiated into it as early as possible.
- Many girls have their first menses in their husband's house.
- Since the father usually pays the school fees, he decides if and when to withdraw a daughter from school for marriage.
- Preference is given to education of boys, since they are the ones who will become breadwinners and household heads.
- Women are socialised to accept their domestic position as “*God-assigned from the time of creation*”.

Access to health care:

“What can these women do?”

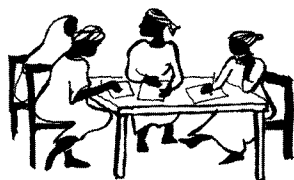


- Economic constraints restrict women's ability to seek appropriate treatment.
- Women's health is often considered less important than the welfare of husbands and children.
- Women use self-medication and traditional medicines as a practical coping mechanism.
- In some societies, even if women have the money, they are reluctant to seek permission to go to the hospital for fear of being accused of socialising outside the home or visiting a boyfriend.
- Married women often need permission from their husbands or mothers-in-law before visiting a health facility. Unmarried women need permission from their parents.
- Men often find out about their wives' illnesses only at night when the woman is unable to perform her sexual "duties".

Health facilities: *“Are women put off using them?”*

- Women are sometimes discouraged from visiting health facilities because of the negative attitude of staff if they do not have the right clothes or cannot speak the lingua franca.
- Lack of privacy, and the impatience of formal health providers, compares unfavourably with the attitudes of traditional healers.
- Incomplete treatment resulting from financial constraints, and inadequate information regarding the dosage, results in the recurrence of certain ailments. As a result, confidence in the modern health sector has been eroded.

Establish communication teams



The basic criteria for establishing communication teams was that there should be a balance of social science, communication and medical input as well as commitment to working in partnership with communities.

In Kenya the team was made up of:

- a medical anthropologist/social scientist;
- a communication specialist/radio producer experienced in distance education and establishing radio-listening groups;
- a medical doctor with experience working with rural communities;
- a graphic designer with experience in textbook illustration;
- research assistants from the community.

In Sierra Leone the team was made up of:

- a health/social science researcher;
- a health educator;
- a medical practitioner with experience in community medicine;
- a radio producer;
- an illustrator;
- a production company responsible for script writing and recording;
- research assistants experienced in qualitative research.

In Nigeria, the team was made up of:

- a medical doctor specialising in public health;
- a sociologist experienced in qualitative research with rural communities;
- a radio producer at the Kaduna State Media Corporation;
- an illustrator.

Develop a partnership with communities



In all countries, participating communities made crucial contributions. The process of achieving their collaboration involved community visits and meetings and approval at each stage of product development. The main methodology used was focus group discussions, a social research technique in which homogeneous groups of up to 12 people discuss in

depth their attitudes to an issue or a product. The concept of involving communities in making radio programmes and illustrations was new to many of the professionals, and the task was approached with excitement.



1. Communicate research findings to communities

Following the initial research, the teams returned to participating communities to give feedback and validate research findings. Although the ideal was to have a continuous relationship with one community throughout the process, this was only possible in Kenya. In Nigeria one of the nomadic Fulani communities that had participated in the initial research had migrated, and a substitute community was identified. In Sierra Leone, the war rendered the earlier community inaccessible, so a new community was substituted.

2. Discuss communication formats

Each community group discussed the proposed participatory radio programme, complementary illustrations and strategies for disseminating health information to rural women. The teams then negotiated with the women and agreed on topics for the development of the programmes.

3. Gather additional information

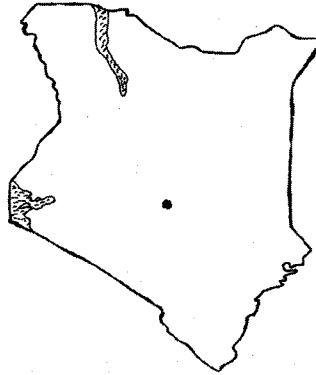
Where necessary, additional information was collected through rapid assessment procedures. Focus group discussions were used with women only, men only and mixed groups.

4. Involve communities in communication development

Communities were involved in the design and pre-testing of materials through team visits to communities and group meetings. However, the approaches varied between country teams, reflecting the different cultural settings, health issues addressed and logistical constraints. Methodologies for developing participatory radio and illustrations are described in more detail in Chapters 3 and 4. In the following section, country team variations in the process are described.

Kenya

The study site: Tharaka-Nithi District



The study and the communication intervention were conducted in Tharaka-Nithi District in Eastern Province, about 250 kilometres from Nairobi, the capital. Two study sites were chosen: the Tunyai and Chiakariga locations. The district has a total population of 293,237 people and annual growth rate of 3.3% (1989 census). The ratio of males to females is approximately 1:1, but in terms of actual residents, fewer males live in the area, because they have migrated for work.

Methodology

Based on the findings from the HWCG research and other resource materials, the communication team developed messages on malaria and gender issues. Three focus group discussions were held with women, men, and men and women together. The mixed group was held at Chiakariga, while the women's and men's groups were in Tunyai.

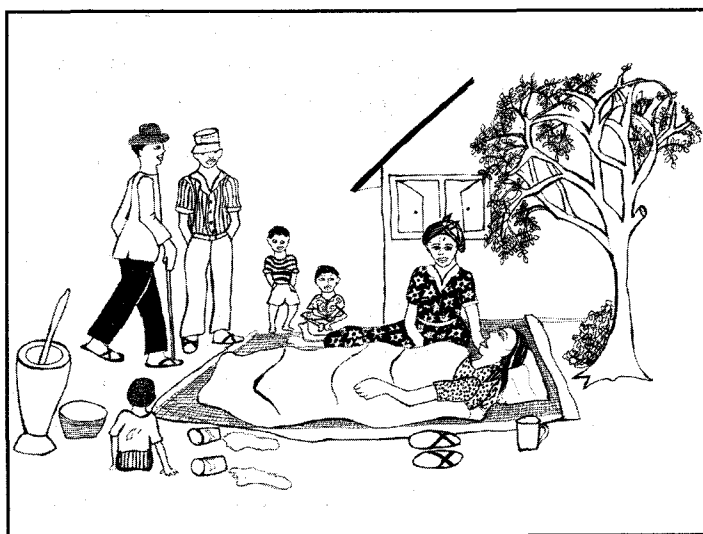
The process began with a visit to the two communities. Discussions and feedback on the findings from the HWCG were held. The groups validated and identified with the health problems but added new health needs, especially amoebiasis, since water is a major problem in the community. Alcoholism and the abuse of women by their husbands were identified as social problems.

After discussions and negotiation, the groups prioritised their health problems and decided to focus on malaria. They then reviewed and modified the radio messages and added more information on gender and ways of coping with the disease. Although radio was said to be an acceptable medium of communication, the groups identified other communication channels such as the *barazas* (public meetings), songs through radio, village-to-village meetings and radio-listening groups.

The group discussions helped to:

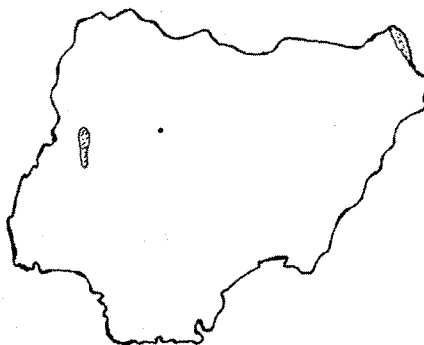
- identify communication structures at the family and community level;
- identify the various roles of family members and friends when women are ill;
- map out the health resources in the community, such as distances travelled to health facilities, shops (canteens) etc.;
- contextualise malaria and gender in a story relevant to the Tharaka community;
- develop and test various dramatic situations and other formats such as drama, dialogue, role plays, question-and-answer methods.
- produce radio segments and illustration materials.

The communication team worked with the groups in a participatory way in developing the radio programmes. The illustrator worked with women to develop visuals with which the community could identify.



Nigeria

The study site: Makarfi Local Government Area



The study and intervention were carried out in Makarfi Local Government Area (LGA), Kaduna State. The location is an agricultural area. According to the 1991 National Population Census, Makarfi has a population of 211, 368 with a 2:3 male to female ratio and 3% birth rate. The study covered three of the five primary health care districts, each of which was chosen to represent a cultural group, namely Hausa, Fulani and Maguzawa. In the villages of Makarfi, Hunkuyi and Rumi, the Hausa are predominantly Muslim and constitute 80% of the population.

Methodology

In Nigeria, the project team worked with the women who had participated in the original research. The groups consisted of 12 women in Makarfi, 18 women in Rumi and 7 women in Hunkuyi. Their ages ranged from 20 to more than 60. The majority were illiterate, and about 10 were attending adult literacy classes.

The process began with a report back of the earlier research findings. A rapid survey was carried out to assess the availability of and access to radios by the women, their preferred listening times, stations and popular programmes. This was followed by discussion of the proposed participatory radio programmes. There was a general consensus that radio is effective. It allows people to put across their views, and it reaches a wide audience. Women also pointed out that husbands could get to hear of some of their concerns that cannot usually be openly discussed.

The focus of the radio programmes was on reproductive health. Groups identified the reproductive health issues they wanted covered in the programmes and came up with the following list:

- STDs;
- complications of pregnancy and child birth;
- health services-related problems (lack of drugs, staff attitudes, cost of treatment etc.);
- VVF;
- lack of transport to convey obstetric emergencies to the hospital;
- reproductive health training of traditional birth attendants.

After further discussion, it was decided that the team would focus on pregnancy and pregnancy complications, and problems associated with early marriage and STDs. These topics were the basis for the first three programmes.

Pre-pubescent marriage is more prevalent in the Hausa communities, so the team worked with the Makarfi women for the development of the programme on early marriage and VVF. The Rumi women participated in the development of the programme on STDs because they expressed considerable concern about their husbands' relationships with commercial sex workers. Pregnancy and pregnancy complications were taken up with the Fulani women of Hunkuyi.



Sierra Leone

The study sites: Western Area



In Sierra Leone, the intervention was carried out two rural areas. The first was in the Mountain Rural District, which is one of the four rural districts of the Western Area. This district lies north of Greater Freetown, the capital, and is made up of five villages. These are Leicester, Gloucester, Bathurst, Charlotte and Regent. National Statistical data from the 1985 census show that the Mountain Rural District has a population of 3,070 with the majority of people living in Leicester, Gloucester and Regent. The researchers selected Leicester and Gloucester villages. The second site is 17 miles from the capital Freetown. The villages with an estimated population of 10,000, are Limba Corner, Marouth, John Thorpe, Konddow and Gbongbo.

Methodology

In Sierra Leone, the process began with identifying an appropriate theme and sub-themes from the findings of the earlier research. The main theme selected was "health-seeking patterns of women". Messages developed focused on the constraints, coping strategies and health-seeking behaviours of rural women. Two sub-themes, STDs including HIV/AIDS, and malaria, were used as examples.

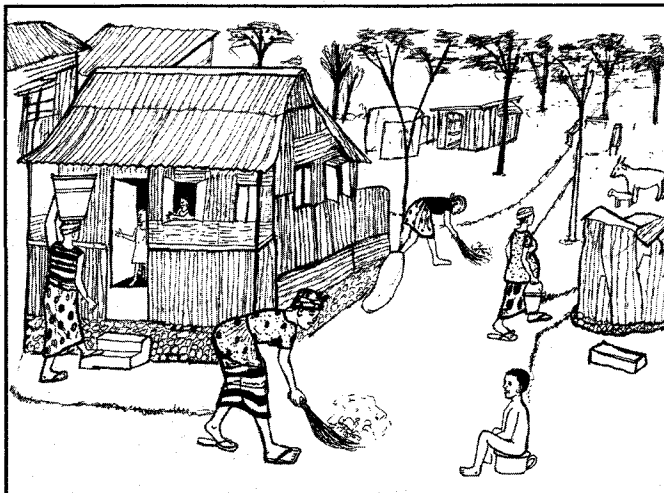
A case study on STDs illustrated problems of stigmatisation, cultural constraints on treatment, self-medication and related community factors. HIV/AIDS was discussed, focusing on perceptions and knowledge of transmission of the disease, prevention, myths and

misconceptions, and support of the sick and their families. The case studies on malaria depicted typical health-seeking behaviour for this common disease.

The project was introduced to the community, and research findings of the earlier research for the development of the HWCG were clarified. There was little statistical data on the community, so after the first meeting with the village leaders, a questionnaire was used to collect data on basic demographic patterns in the area.

This community was found to be slightly different from that involved in the earlier HWCG research, although religious background (Muslim) was similar. Alcohol consumption was high, and there was evidence of spousal abuse. Also, although over 90% of the women were illiterate, they were higher income earners and had more contact with the public.

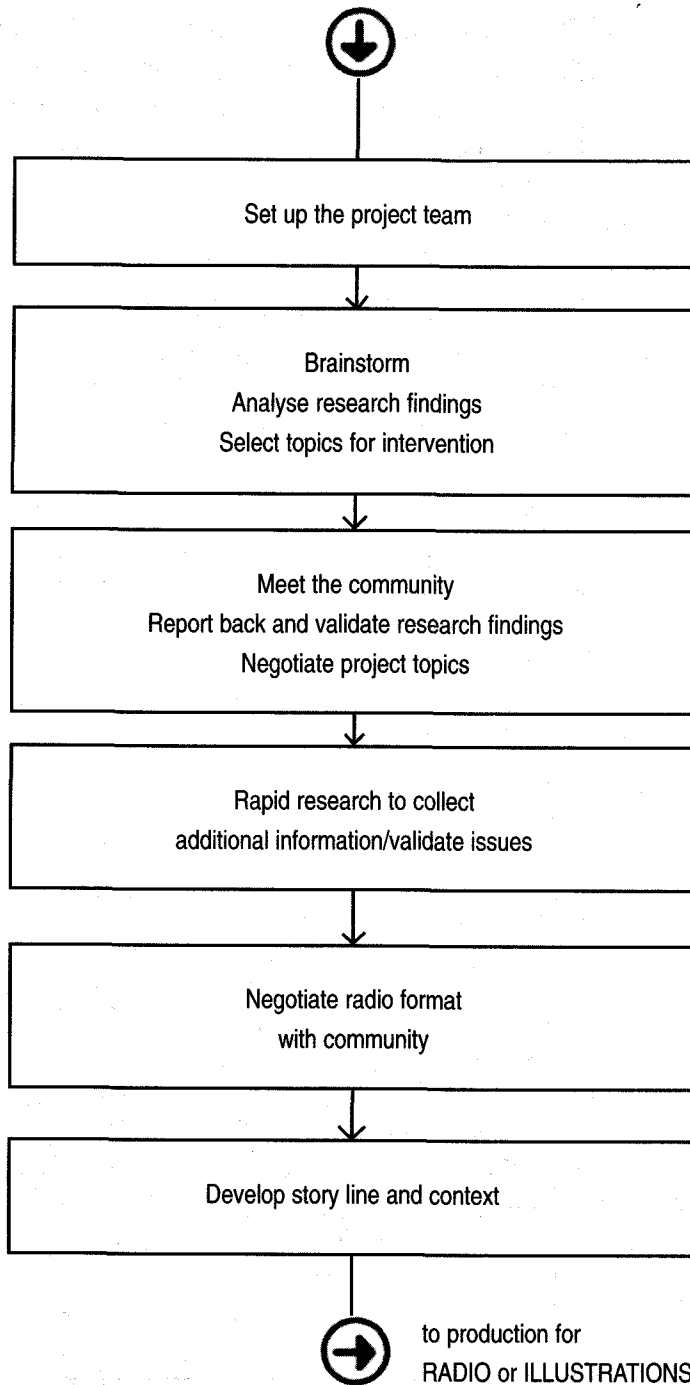
After negotiating with the community on the radio format for the programme, participating community groups built up scenes from the case studies collected during in-depth interviews and focus group discussions. A mixed group of men and women of all ages was used to validate or challenge issues and to ensure that the content of the script portrayed the typical picture of rural life. The women participated in role playing, and because the community is small, the team was able to meet with all the women and men, and a consensus was reached for the proposed programmes. Thus the episodes for a five-part drama series were developed.



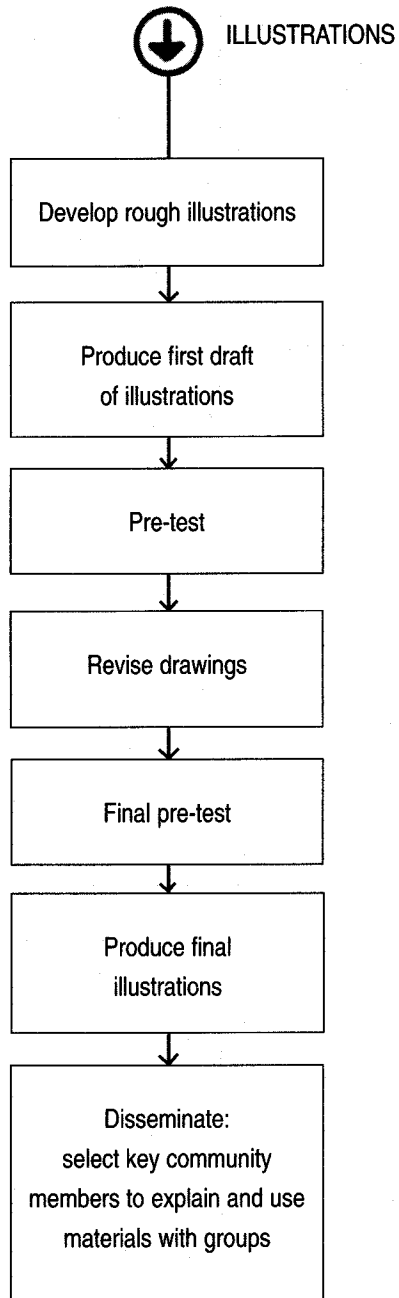
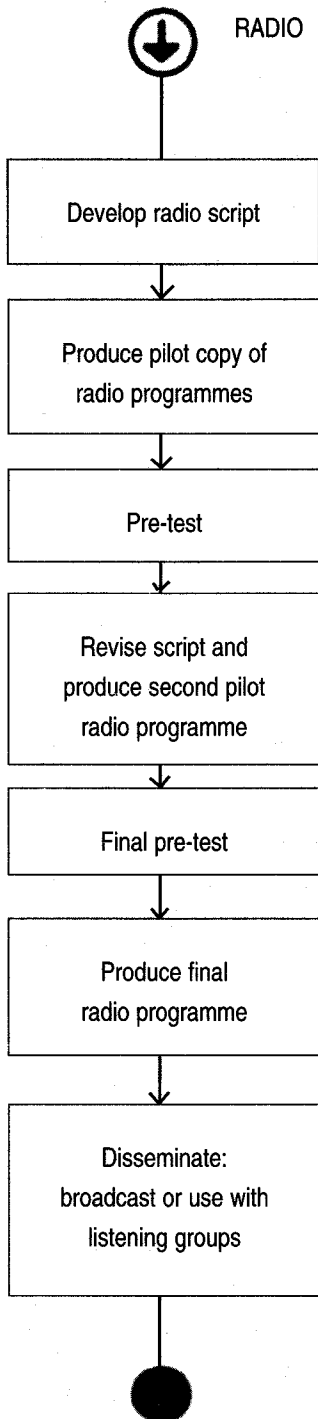
Step by step

"A Journey of a thousand miles begins with the first step"

Preparation



Production



Summary of Gender, Health and Communication Teams and Activities :

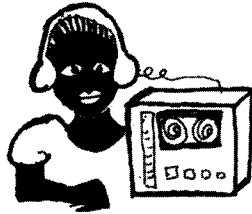
February-July 1996

	KENYA	SIERRA LEONE	NIGERIA
AREA	Tharaki-Nithi District	Mountain Rural District	Makarfi LGA
COMMUNITY PARTNERS	Community members of Tunyai, Chiakariga	5 villages of Rokel area; Cassada Farm - all community members	Community members of Rumi, Hunkuyi, Makarfi
COLLABORATING INSTITUTIONS	University of Nairobi, Kenyatta Hospital, Institute of Education, Education Media Service	Ramsy Medical Laboratories, Ministry of Health, Spence Productions	Ahmadu Bello University, Kaduba State Media Corporation
TEAM MEMBERS	Medical Anthropologist, Communication Specialist, Radio Producer, Graphic Designer, Medical Doctor, Research Assistant	Researcher, Health Educator, Medical Doctor, Script Developer, Radio Producer, Illustrator, Production Company, Research Assistant.	Medical Doctor, Sociologist, Radio Producer (2), Illustrator, Primary Health Care Worker
HEALTH ISSUES SELECTED	Malaria	Women's health seeking behaviour (malaria, STDs, HIV/AIDS and pregnancy)	Early Marriage/(VVF) STDs Pregnancy and ANC
MAIN GENDER ISSUES	Women as frontline health providers Neglect of sick women	Women as carers of the sick	Women's powerlessness in decision making
TITLES: RADIO PROGRAMMES	'Small Insects, Big Trouble' Fighting Malaria. Radio segments: 1. Kagendo's story; 2. Health talk in a clinic, 3. Men discuss malaria, 4. Pregnant women share information.	The Road to Good Health, Episodes: 1. Facing the issue 2. Osusu (thrift club) 3&4. Let's talk about it. 5. 'How do you tell him?' 6. How to solve it 7&8. Pregnancy 9. A child is born	Healthy Women, Healthy Community: 1. VVF a Preventable Social Tragedy 2. Your Lifestyle, Your Health 3. Your Pregnancy, Your Health
FORMATS	Drama, Dialogue, Interview, Role play, Question and answer, Health talk	Serialised Drama, Discussion	Drama, Discussions
PROGRAMMES BROADCAST			KSMC June & July 1996 Sunday 22.30 and Monday 12.30

Chapter 3

Partners in Radio Programmes

The process of making radio programmes in partnership with communities varied among country teams. The different approaches to developing the script and the accompanying illustrations, negotiating the format and pre-testing the programmes are described in the following sections.



The Nigerian experience

Negotiating the format

In Nigeria pre-recorded programmes in three formats were played to the groups. After listening, they decided they preferred the drama format.

Developing the script

The team worked with the Makarfi women to develop a story line on the problems associated with early marriage and vesico-vaginal fistulae (VVF), pregnancy and antenatal care. The group enriched the dramas with roles and characters from their daily existence and highlighted the gender issues. After working meetings with the women, a script was developed, fine-tuned by the team and then produced professionally. The following example shows how the health and gender issues were interwoven into the story dealing with early marriages and VVF.

The story line

"Pikin de born pikin. Na wa oh!"

Baby giving birth to baby

A 12-year-old girl, A'isha, was attending primary school in the village. She was performing very well, even better than her brothers. She had an ambition of going to a university and possibly becoming a nurse or doctor.

When she was preparing to sit for the secondary school common entrance examination, a rich elderly Alhaji with three wives saw her and fancied her. He approached her father for her hand in marriage. The



father consented in spite of her mother's protest.

Soon after marriage, A'isha became pregnant. She was not allowed to attend an antenatal clinic (ANC) by her husband, because none of his other wives had ever done so and they had all delivered without incident. When eventually she went into labour, it was a very difficult one. In spite of the herbal and other ministrations by the traditional birth attendant, she still could not deliver after three days. The Alhaji then took her to the hospital where she was operated upon to deliver the baby. It was a stillbirth.

After this she started leaking urine. On her return to her husband's house, he sent her back to her parents. The parents kept her isolated in a room of her own. Other members of the family started ridiculing her.

Unable to withstand such treatment, A'isha left the village in search of cure in the city and had to resort to menial jobs and begging to get some money for her sustenance. The treatment she sought in the city eluded her, as she was unable to raise the money required to pay for the surgery.



In the meantime her childhood friend, Binta, had been allowed to continue school and graduated as a medical doctor. One day as Binta was passing along a busy street, she stopped to give alms to a young woman begging. On closer look, she recognised the tattered, smelly beggar as her childhood friend Aisha. On hearing her pathetic story, Binta offered to take her home, then to the hospital and paid for her treatment. The surgery was successful.



Pre-testing

The women

Early marriage of girls is harmful.



Both groups of women appreciated and understood the programme and related the drama to their everyday existence. Some recognised their own contributions from the earlier focus groups, some suggested further additions. For example, they wanted a scene showing A'isha's father finding her begging in the city, so that he could appreciate the effect of his actions on his daughter's life. Another suggestion was that following the successful treatment of her VVF A'isha should complete her education and become a useful citizen in the society.

The lessons of the drama which they mentioned were:

- Early marriage of girls is harmful;
- Girls should be allowed to go to school, because given the chance, they could become important and useful citizens in the society;
- Antenatal care is important. Pregnant women should be allowed to go for antenatal care;
- In the event of difficult or problematic labour, women should be rushed to hospital. Women should not be in labour at home for up to three days as was the case with A'isha;
- Husbands and parents should not reject their wives or daughters if they develop VVF.

Husbands should not reject wives if they develop VVF.



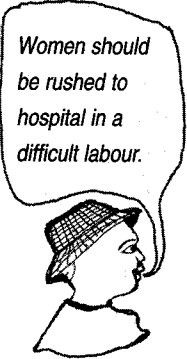
The drama generated a lot of discussion amongst the women. However, they were not convinced of the need to delay the age of marriage for girls to at least 18 years, as recommended in the Nigeria National Population Policy.

The men

Antenatal services should be free.



The men appeared subdued, and it was only with a lot of prompting that they began to contribute to the discussions of the drama. They showed a general understanding of the programme and were able to correctly narrate the story. On the lessons learnt, the men were silent on the role of A'isha's father and her husband. They felt that A'isha developed VVF because of the poor judgement of the traditional birth attendant and the delay before A'isha was taken to hospital. Asked whether A'isha's father was right to have married her off at such an early age, most of them responded in the affirmative, as they said they were conscious of the



Women should be rushed to hospital in a difficult labour.

negative consequences of delayed marriage. Only a few of them thought that early marriage is bad. Also, they felt that A'isha's husband's action was in order, since "when a wife is ill, she becomes her parent's responsibility".

They recommended for inclusion in the drama a call to government to provide adequate maternal health services. They identified the following as strategies for the control of VVF:

- female education;
- provision of free antenatal and delivery services;
- training of traditional birth attendants;
- provision of accessible emergency obstetric services.

Further action

Using the feedback from the community, the programme was modified and a final copy produced. This was then translated from Hausa to English, and the final production was made and regionally broadcast in both languages. Taped sections from the focus group discussions were also extracted and integrated into the "Let Them Live" series of Kaduna State Media Corporation and aired. Future plans include sharing the tapes with seven other radio stations through Unicef's established collaborative relationship with the radio stations. There are also plans to adapt the Hausa radio programme for television.



The Sierra Leonean experience

Negotiating the format

The Sierra Leonean groups were familiar with different formats already, so it was not necessary to play them examples. After some discussion they agreed on radio drama as the most suitable format.

Developing the script

The team introduced the project and presented the findings of the research to the community. Selected groups developed radio programmes of health issues agreed upon by the community and the

team. The women then volunteered to take part in the role play, and some people who had contracted malaria and sexually transmitted diseases (STDs) were willing to act in the drama. The project team and the group agreed on three scenes for the five episodes: typical working day with morning, market and evening scenes; hospital or clinic scene; village meeting on health issues.

The narratives provided during the focus group discussions and the in-depth interviews were used to develop the episodes. The drama centred around a typical village compound with few houses, each housing large extended families. The game of "draughts" was a feature throughout the series as the favourite pastime of men. The importance of a communal area, in this case a tree-shaded area, as a place where discussions are held and community decisions taken, was also highlighted.

Initially, the teams developed the synopses by integrating several case studies, taking into account the cultural and traditional values of the community. From these synopses the scripts were developed by a professional theatre company. However, the outcome of this was unsatisfactory. The programme displayed a top-down approach and lost the sense of community involvement. Therefore, the team reviewed the script, re-visited the community and negotiated to use a single case study as the focus for the story.

The content included direct and modified quotes from the role-playing sessions, and scientific facts provided by the medical expert were built into the script by the script writer. The drama emphasised gender issues and highlighted factual messages to be learnt. However, care was taken not to include too much technical medical information, as this would make the programmes didactic and weaken their entertainment value.



Example Episodes from a five-part serialised drama: "The Road to Good Health"

Episode 2: Osusu: We need a thrift club

Yeli and her husband Momoh return from the health centre. They did not have enough money to buy all of the drugs which were prescribed for Yeli. Momoh goes to the communal tree to ask for a loan from the group of neighbours gathered there. Pa Kargbo, the shop owner, offers to lend some money but it is less than half of what is required to buy the drugs. Momoh is frustrated.



Pa Kargbo says that borrowing money is no solution to buying drugs and suggests that the community should start a health fund. The suggestion is greeted with scepticism at first, but after Pa Kargbo explained the advantages, his friends accepted the idea. It is agreed that every member of the community should contribute monthly to an "osusu", a money saving and lending club (thrift club), specifically for buying medicines.

A meeting of all the adults in the village is called and they discuss the need for the health fund and how it will work. Pa Kargbo, now confident that his money will be paid back, offers to lend Momoh all of the money to enable him to buy the medicines which Yeli needs. After the meeting the men gather to engage in their favourite past time, playing draughts, but Momoh returns home immediately to be with Yeli, depicting a change of attitude to his role as husband.



Episode 4 : Sexually transmitted diseases

Scene 1: Yeli visits her mother

Yeli, the eldest married daughter, visits her family after a period of illness. She has now successfully been treated for malaria and is well again. She finds her mother ill and sitting by the fire despite the hot afternoon sun. Her mother, Musu, is reluctant to discuss her condition with anyone because of the embarrassing symptoms of STD (sexually transmitted disease). Her fear stems mainly from the ostracism, especially by husbands, which other women suffering from STDs have experienced. Yeli, whose confidence in the formal health delivery system is now strengthened, convinces her mother to go to the health centre. She assures the older woman that confidentiality will be respected.

Scene 2: At the clinic

The community health officer (CHO) personally attends to Musu, and agrees not to discuss her illness with anyone without her expressed consent. At first, Musu cannot easily explain her problem, but with skill and patience the CHO tactfully asks the right questions and brings Musu around to opening up sufficiently. Musu describes the symptoms of pain in her back, lower abdomen and during menstruation, as well as the burning sensation whenever she urinates. She acknowledges the change in the smell and quantity of her vaginal discharge. She even reveals the discomfort felt during sexual intercourse which has led her to make excuses to her husband in order to avoid sex. She cries and affirms that she is a faithful wife and attributes the cause of her illness to traditional myths such as stepping on dog urine. She tries not to get her husband involved.

The CHO urges Musu to tell her husband so that he too is treated. That way she will avoid re-infection. Musu is not confident enough to explain everything to him, but agrees to tell him that he is required to go to the clinic in connection with her treatment. The CHO agrees to fill Pa Kamara in about the details of the disease affecting him and his wife.

The significance of HIV/AIDS is introduced, and the importance of preventive measures is emphasised to sensitise the community. However, there was a tendency to dismiss this and to see AIDS as a white man's sickness and a trick to curb the activities of men. The condom was said to reduce the pleasure of young men and to cause problems such as entangling in the intestines of women. Their fears were alleviated by the CHO, who explained the facts skilfully. It was agreed that sensible men are prepared to wear condoms.



"Wan fut soks for di bambye"
(*"Condoms for the unexpected"*)

Pre-testing

The radio programme was pre-tested with groups of young women, old women, men and mixed men and women of various ages. Initially there were many disagreements about the causes of ailments and the gender issues raised in all the episodes.

The women

The young women appreciated the programme, since the problem of STDs is well recognised but almost never discussed openly. The women understood the drama, and they expressed relief that an issue that has been clouded with traditional taboos and myths is being dealt with. In the single-sex group, some shyly admitted to identifying with the signs and symptoms of STDs and asked for detailed information to be provided in a more formal way.

The older women and the aged held firmly to traditional beliefs about the mode of transmission of STDs and preventive methods. It was not easy to convince them to change those beliefs. However, both women's groups were eager to know the strategy used to tell the husband about the ailment. They wanted the scene to continue, and they felt that men's involvement should be demonstrated.

The men

The men's reactions were mixed, especially in this episode. Unlike the women, they did not view STDs as a serious matter; they identified STDs in men as a necessary part of growing up.

These days there is no believing.



However, some felt sorry for the women because of the symptoms identified in the drama.

The mixed group

In the mixed group men accepted their part in the sickness and acknowledged that their support is needed in both the treatment and prevention of STDs. They also would like the series to continue to the end, wherein the wife and husband get treated successfully. When asked about strategies which wives should use to approach a husband on this issue, they intimated that the most appropriate time should be when they request for sex at night. They also emphasised that instead of women giving excuses, which makes men suspicious, they should come straight out with the facts.

AIDS does not concern me!



The message on HIV/AIDS was first received with indifference and misgivings, but after the medical personnel in the team explained the seriousness of the disease, the group was clearly concerned. They made the following points:

- Not everyone takes AIDS seriously: some think they are immune, others say they are no longer at risk because they are not sexually active;
- Condoms reduce pleasure but provide protection during unexpected encounters or when husbands can't be trusted;
- Some people find it difficult to discuss sex openly.

I will always carry a condom "for di bambye"



Further Action

The messages are incorporated into the drama in such a way that the audiences are entertained, educated and stimulated to follow subsequent episodes. The scripts were originally written in Krio, the lingua franca, and pre-tested in other communities. To further develop the series, another programme is needed. Issues to cover include the importance of completing treatment and how sexually transmitted disease can be prevented. The request for detailed information on STD in a more formal format could be met by producing a radio programme in the form of a dialogue between a member of the community who asks questions and a medical expert who responds.

It is difficult for me to talk about mama and papa business.



The Kenyan experience

Negotiating the format

In Kenya, the team worked with one community to transform the messages on malaria and gender into five radio formats, namely: drama, dialogue, role play, question/answer and a talk. These formats were then pre-tested in Tunyai and Chiakariga communities and found to be suitable formats for communicating malaria and gender messages and also effective and appropriate as a drama for rural radio programming.

Developing the script

Two focus group discussions helped identify communication structures at family and community levels. The discussions also identified roles played by the family and community when a woman is ill. Through this process, the story of a woman called Kagendo emerged. The story brought out the social structures that control women, determine how their illness is managed, and the roles played by women friends and family members. The story was then acted out by the community and improved as it progressed.

The gender and health messages from the research findings were discussed and incorporated into the story. The community then acted out the scenes, and after two days of practice they were recorded and produced as a radio magazine programme. In addition to the radio story, four radio segments using the following formats were developed. These were a dialogue between Kagendo and her mucoore about anaemia and ways of preventing malaria when pregnant; a role play/discussion in which Tharaka men drinking "marua" are making jokes and discussing malaria; a question-and-answer format in which a medical doctor is being asked questions about malaria by his age-mates; a talk in which a woman doctor is giving a health talk on malaria in an outpatient clinic.

After pre-testing, the radio segments were translated into English. Four 15-minute Kitharaka scripts were developed and recorded. Appropriate sound effects and songs were recorded in Tunyai and later merged with the words in the studio. Young Tharaka actors and actresses were used to voice the English and Tharaka scripts.

The story line

**“Mucoore (my friend),
small insects, big trouble!”**



Kagendo is sick with malaria. Her husband, M'Makembo, spends his time drinking “marua” with his friends and doesn't care about his family or wife. Kagendo had a trusted friend, a “mucoore”, who comforts her and takes action during times of illness. They also share information on topics like pregnancy and malaria.



Kagendo is lying on a mat outside her hut. She sends her daughter Makena to keep the cooking fire going. Her mucoore comes to visit, finds her sick and questions her on her illness and what medications she has taken. She had taken left over drugs from her son's last illness. She has also taken indigenous herbs and a local brew made from honey. Her mucoore asks her what the husband has done since she got sick. He has sold a cow but has not used the money to treat her illness. Various gender issues are raised in their discussion, such as the neglect of the wife by the husband, the work burden on women, lack of financial resources among women and the problem of alcoholism in the community.

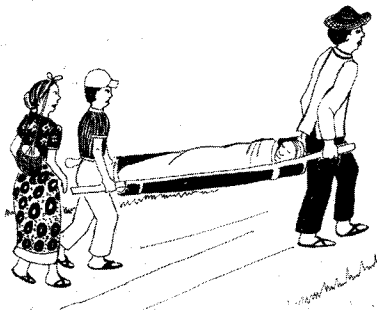


The brother-in-law visits, expresses surprise that the brother left his wife sick, and asks about the symptoms and the medication she has taken. He sends the son, Gitonga, to buy malaria drugs at Mr. Nyaga's shop and goes to look for his brother. At Nyaga's shop, Mr. Nyaga asks Gitonga about the symptoms of his mother's illness and sells him chloroquine tablets. He explains the dosage. Gitonga returns with the tablets and passes on the information. Mucoore gives Kagendo 4 chloroquine tablets

and tells Kagendo that she will come back in the evening and for the remaining days to ensure that she takes the correct dosage.

The drunken husband enters with the brother-in-law. He says he is not sure whether the wife is sick or just pretending, since she has been doing so from the time he married her. At this point, the brother calls him aside and tells him that his wife is seriously sick with malaria and that she is not malingering.

On the fifth day, after completing the treatment, Kagendo's condition has become worse. She is now vomiting, can't walk and feels drowsy. The medicine she has taken has not been effective. The husband is now worried and realises the wife is not malingering. He sends for his brother.



He tells his brother that his wife's illness has become worse and that he has sent Gitonga for Nyaga's vehicle to carry her to the hospital. His brother makes an "itarati" (the traditional Tharaka stretcher) to carry Kagendo to the hospital instead of waiting for the vehicle. M'Makembo sends Makena (his daughter) to call his wife's mucoore. When she arrives, he tells her his wife is now very sick and he fears for her life. He requests mucoore to accompany them to the hospital, which she does after organising her household and leaving a message for her husband saying where she has gone. The patient is placed on the itarati, and the safari to the hospital begins.



The doctor examines her, asks for the symptoms, the medication she has taken and tells them that she has to be admitted. She reassures them that Kagendo will be fine. She also explains that the reason the drugs were not effective is because of parasite resistance to chloroquine tablets. So even though she took the correct drugs and correct dosage, she still became sick.

The mucoore and brother-in-law then sit in the waiting room and listen to a talk (by a woman doctor) on malaria.

A later segment shows men discussing malaria while drinking. They have many questions to ask one of their age-mates, who is a doctor. He returns the following day for a full discussion with them.

In another segment we find the two women friends discussing anaemia in pregnancy and how to prevent malaria when you are pregnant.



Pre-testing

The pre-testing was carried out in Tunyai and Chiakariga, areas in which the original research was done. The radio drama was played to women and men in Tunyai and to mixed groups in Chiakariga.

We have to give the man money or else he will beat us.



The women

The women identified with the gender messages in the programme and enjoyed the drama. This generated discussion on the gender issues, especially the problems of alcoholism among their men and general neglect by husbands. One woman said: "We women carry a heavy burden of taking care of the men, and their family." They further explained that women provide basic needs for their families, e.g. food, clothing, school fees and even give their husbands money (albeit unwillingly) to go and drink. The women explained that the men demanded money from them whenever they sold farm produce or generated income from their work. The women explained that sometimes they gave money to men for fear of their lives. As one woman said: "Andu anume te menga" (men are not good).

Women are the pillars of the home.



The men

The group understood the issues raised in the story but felt that the story was incomplete. They were more concerned about what happened at the hospital and asked questions like "Did she get well? What medicine was she given?" and whether the use of traditional medicine was right or wrong. The men did not seem to have enjoyed this story, and many appeared absent-minded. This may be partly because the issues of alcohol and control of money challenged their status.

The mixed group

The mixed group identified with the story. They clearly understood the messages on malaria and the gender issues raised by the drama. Both sexes agreed that the irresponsibility of men and alcoholism are problems in their community. The men agreed that it was important for them to know the condition of their families every morning before going out, and acknowledged the need for family communication between women and men. The men seemed ashamed and downcast as the story was told. This was because the story seemed to mirror their lives,

*Woman, if you
don't take care
of me properly,
I can marry
another wife*



*It's a
woman's
burden.
He owns me.*



especially family neglect and alcoholism. The women in the group enjoyed the sections of the story which appeared to be "telling off the men". Although women in the group discussed the problem of alcoholism, they appeared restrained, compared with the women-only and men-only groups. Both indicated that they had learned some lessons, for example:

- the importance of co-operation in the family;
- the value of a trusted friend and the need to support women;
- the importance of treating malaria early;
- the proper use of malaria drugs and taking the sick to hospital;
- responsible use of family resources;
- use of indigenous plants such as the neem tree and mukao for preventing malaria and controlling mosquitoes.

Further action

The story of Kagendo will be developed into a series of radio programmes. The drama will bring out health and gender issues arising from the research findings and the pre-test results. The radio programmes will be distributed via audio cassettes to existing health groups, clinics and listening groups. The team will negotiate with existing community groups to explore the possibility of initiating listening groups in Tharaka, the study community. If possible, the programmes will be aired by the Kenya Broadcasting Corporation (KBC). An accompanying booklet will be produced.

Excerpts from radio scripts:

Nigeria

Excerpt from the script of the radio drama "VVF - A Preventable Social Tragedy"

(Translated from Hausa)

Scene II

SFX: VILLAGE ACTIVITIES IN ALHAJI BUBA'S COMPOUND

ALH.BUBA: *Talatu!*

ALH.BUBA: *Did you see Alhaji Idi and Malam Sule?*

TALATU: *(SURPRISED) Really? They have never been here before. What did they want?*

ALH.BUBA: *They came on behalf of Alhaji Lukman. He wants to marry A'isha.*

TALATU: *(SHOCKED) A'isha, my daughter? Alhaji, she is just twelve.*

ALH.BUBA: *How old were you when I married you? (PAUSE) Weren't you her age?*

TALATU: *(PLEADING) But times have changed Alhaji.*

ALH.BUBA: *(STERNLY) Listen Talatu, Alhaji Lukman saw A'isha, liked her and wants to marry her. I have given him my consent already, and I'm just informing you.*

TALATU: *Which Alhaji Lukman is it?*

ALH.BUBA: *Alhaji Lukman the car dealer. He is very rich. I think he's the richest man in the village.*

TALATU: *The one with the big red Mercedes car?*

ALH.BUBA: *Yes, wouldn't he make a good son-in-law?*

TALATU: *(SURPRISED) Alhaji, he is old enough to be her grandfather! He already has three wives and many grandchildren, some her age. Please Alhaji, please don't consider it again.*

ALH.BUBA: *Why? He is rich and A'isha will be comfortable.*

TALATU: *Alhaji, A'isha is a very brilliant girl and wants to go to school. Why don't you allow her to at least go on to complete secondary school.*

ALH.BUBA: *But can't you see how mature she already looks?*

TALATU: *(PLEADING) Please Alhaji, A'isha's ambition is to be a doctor. Can't we encourage her? In fact, she just asked me for money for her entrance examination forms.*

ALH.BUBA: *(EMPHATICALLY) Hajija Talatu, am I A'isha's father or not?*

TALATU: *(APOLOGETIC) You are.*

ALH.BUBA: *Okay, I'm marrying off A'isha as soon as she finishes primary school. My decision is final. So break the news to her.*



Sierra Leone

Excerpt from Episode IV: "Lets Talk About It" (Translated from Krio)

Yeli has come to visit her mother, Musu, and finds her sitting by the fire under the burning sun. She is ill but she is reluctant to talk about it to anyone.

YELI: *I'm your daughter. And I'm an adult now. I care a lot about you. (CHANGE TO A MORE SERIOUS WHISPER) You can trust me.*

MUSU: *I know sweetheart... I really do... but ... It is... no, nothing.*

YELI: *Come on, Mama. You've been ill for too long. Talk to me.*

MUSU: *So long as you promise to tell no one. I mean no one.*

YELI: *All right then. Absolutely no one. I promise.*

MUSU: *This back really hurts. Then the pain goes around to my stomach, below the navel. I'm bent over in pain. I just feel bad.*

YELI: *And all this time... you never told anyone?... so what else is painning you?*

MUSU: *Well, I dread going to the toilet. I have this burning pain when passing urine.*

YELI: *And you never even told grandma Binti?*

MUSU: *How could I tell your father's mother? ... Or his other wife ... such a thing?*

YELI: *They both care about you... A lot. They would have helped.*

MUSU: *Perhaps! But I couldn't take any chances. When Marie was accused of sleeping with another man, she was publicly disgraced.... Because she talked to someone she trusted.... And God knows I've been a faithful wife.*

YELI: *Mama, please come with me to the health centre tomorrow. I am going for a check-up. The health workers will help you.*

MUSU: *And then they will laugh at me.*

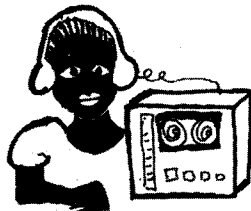
YELI: *No, Mama, the health workers will give you medicine to help you, just as they helped me. They won't tell anyone if you ask them not to.*

MUSU: *Are you sure?*

YELI: *Of course I'm sure. The community health officer would talk to you alone, in a room.*

MUSU: *My child, one can't be too careful in this world. Just remember your promise, and I'll go to see what this health centre can do for me.*

YELI: *Thank God! And you'll get well soon. You'll see.*



Kenya

Excerpt from Radio Magazine on Malaria (Translated from Tharaka)

SFX: FADE IN 30" - SOUND OF A HOMESTEAD - MIX - SOUNDS OF CHICKEN, GOATS, SHEEP, COWS AND CHILDREN PLAYING

FADE OUT QUICKLY BRING IN SOUNDS OF A SICK PERSON

KAGENDO: (FAINTLY, BREATHING DEEPLY) *Makena! Makena iii!*

NARRATOR: *Makena is her girl child. She calls her but not her son Gitonga, who is also around.*

MAKENA: *Mama, are you calling me?*

KAGENDO: *Yes, come closer. I can't speak loudly.*

MAKENA: *Yes, Mama.*

KAGENDO: (SLOWLY AND HEAVILY) *check the fire. Keep checking it and see that the food is cooked.*

MAKENA: *Yes, Mama. I'll do that.*

NARRATOR: *The girl child helps her mother when she's sick. Mothers continue to look after the family even when they're sick. The only solace is another woman friend. Kagendo is visited by her "mucoore", called Karimi.*

FADE IN 20" HOMESTEAD SFX AND UNDER

KARIMI: *Hodi. Mother Gitonga. How are you?*

KAGENDO: *My friend. I think I have malaria.*

KARIMI: *Why are you sleeping outside? Its so hot and the sun is fierce.*

KAGENDO: *I'm feeling cold.*

KARIMI: *You are cold! What else are you feeling?*

KAGENDO: *I'm also sweating and shaking. Feeling cold and hot.*

KARIMI: *Let me feel your face. (PAUSE) Yes, your face is warm. Let me see your eyelids. (PAUSE)*

The inside is pale. My friend - you are right. You have malaria.

KAGENDO: *I'm feeling cold. I've a severe headache, backache, and I'm sometimes vomiting when I eat food.*

KARIMI: *When did you fall sick?*

KAGENDO: *Since Monday up to now.*

KARIMI: *And why can't you sleep in the house?*

KAGENDO: *I thought the sun could give me some warmth*

KARIMI: *Where is your husband?*

KAGENDO: *He has gone to take beer at Njeru's place.*

KARIMI: *He left before you took drugs?*

KAGENDO: *Does he care? If I die, he can remarry another daughter of a woman.*

KARIMI: *My friend, oh, my friend*

KARIMI: (LOUDLY) *Gitonga....!*

NARRATOR: *Her friend calls her son.*

GITONGA: *Yi.*

KARIMI: *Come quickly.*

FOOTSTEPS OF GITONGA APPROACHING FADE UP 10" AND THEN OUT

GITONGA: *Yes, Mama...*

KARIMI: *Go and call your uncle.*

NARRATOR: *Gitonga runs to call his father's brother. Karimi and Kagendo continue their conversation.*

Chapter 4

Partners in Illustrations

In all three countries there were posters in health centres. However, not everyone goes to the health centres. Also, many of the existing health education illustrations in use have been produced by medical and communication experts without involving the community. Although the illustrations are quite informative, some people have problems with the size, understanding the messages and relating them to their own lives.



Why make new illustrations?

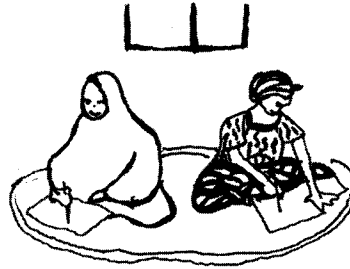
In this project, communities were involved and encouraged to influence the illustrations so that they showed familiar situations. People actively commented on the illustrations through the stages of design and pre-testing. Using a participatory approach enabled the illustrators to depict issues and scenes which the community could identify with.

The overall idea was that illustrations should be made in partnership, involving the community, the illustrator, the scientist, nurses, health workers and other communication experts. The composition of the teams and the way of achieving a partnership varied. In this chapter we describe some of the principles that guided the approach and how these were applied respectively by the different country teams.

Making the illustrations



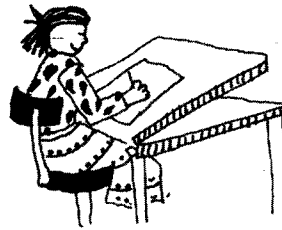
1. Test other approaches and illustrations



2. Involve village women in drawing and commenting on existing drawings



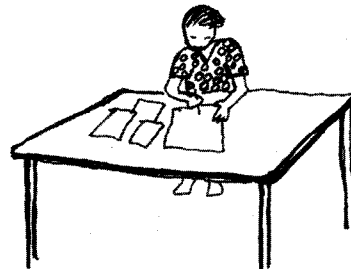
3. Illustrators work with communities and get exposure to the village scene



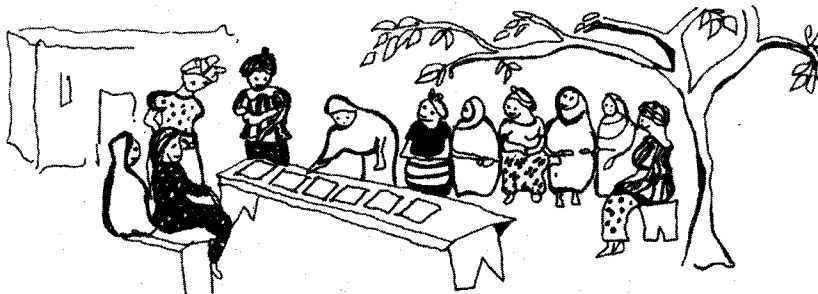
4. Develop first draft illustrations



5a. Pre-test and revise



5b. Revise illustrations based on pre-test



5c. Final pre-testing leading to product and use with community groups