

# **Jordan Badia Research and Development Programme**

## **Health and Education Survey - Summer 1994**

### **Preliminary Findings**

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#### **1. Introduction**

During the summer of 1993, as part of the development anthropology component of the joint programme being carried out under the auspices of the Higher Council for Science and Technology (HCST), Jordan, and the Royal Geographical Society (RGS), United Kingdom, I participated in a primary survey<sup>1</sup> of village inhabitants residing in an area constituting part of the Northern Badia of Jordan<sup>2</sup>. In June of 1994 I returned to Jordan with a colleague, Carole Rehfisch, to participate in a joint health and education rapid appraisal in which my colleague was to lead the former component and I the latter. Jointly, we conducted some 18 interviews between 13 June 1994 and 22 June 1994. At this point, due to unforeseen circumstances, my colleague terminated her work with the programme. At the request of the then Programme Director in Jordan, I agreed to proceed with the work that we had begun, adding the health component to my former agenda. My intention was to work until September but I, like my colleague before me, was forced to terminate my work prior to its completion (on 16 August 1994).

##### **1.1. Objectives**

Development projects have historically been approached from a top/down perspective with funding allocated to projects which are designed by executive administrators and so-called development experts with little or no consideration being given to the needs, aspirations and practices of the said 'beneficiaries' of such projects. Asking the individuals to be 'developed' and whose socio-economic circumstances are to be 'improved' about their own views and willingness to become active rather than passive participants in their continuing development is all too often deemed to be an unnecessary and costly exercise. Quite to the contrary, a disregard for the importance of the individual's contribution and participation in development programmes has proven to be the most costly mistake with failed project after project testifying to the need for joint co-operation and communication between development planners and local inhabitants. See the paper considered, in Dec 1994, by the Badia Programme Steering Committee, entitled: "

For this reason, the joint health and education appraisal focused on the attitudes of the local inhabitants towards past, current, and future provision of these services and is biased towards those individuals participating in the reception rather than in the provision of

services (although these are clearly not static, bounded categories). As such, I acknowledge its inherent deficiencies and prejudice. It may best be placed and considered as a complementary rapid appraisal and compared with other studies whose bias is towards the service provider<sup>3</sup>. However, it is my contention that such short-term appraisals must be viewed as such - as indicators of contesting views to be further explored, and not as final dictums.

## 1.2. Methodology

Field visits were conducted on a daily basis when adequate resources, i.e., transportation, driver, and Jordanian counterpart were available to the researcher. On a number of occasions, I provided my own transport so as to facilitate the field research. Between four and six interviews per day were conducted and included as many representative members of the community as possible. Such members of the community included household members (men, women and children), healthcare and education service providers who resided both within and outside the region, and village administrative officials and employees. While I acknowledge that the sampling of individual villages was so small as to be statistically insignificant, I was able to cover most of the villages in the region - some 30 out of 35 villages and as such the work provided a sound basis for gaining an understanding of some of the principle concerns of the inhabitants across the region. The concentration of interviews occurred within households (with as many members of the household included in the interview as possible) followed by interviews with healthcare and education staff and then by interviews with village administrators.

My aim was to keep the interviews as unstructured as possible while covering the relevant areas as outlined in the proposal (below). Structured interviews may be used to obtain certain, rudimentary information for statistical analysis but this method alone is an ineffective means of obtaining the kind of information on which development policy may be established and implemented. The focus must rather be on unrestricted dialogue; including the discussion of other areas which influence attitudes towards health and education. Denying the inhabitants the opportunity fully to participate in the decision-making process only results in a top/down implementation which the inhabitants will justifiably reject.

The research topics on which the dialogue<sup>4</sup> was focused are as follows:

### Health Component:

1. Attitudes of local inhabitants towards:
  - a. National schemes: Immunisation Programme.
  - b. 'Traditional' medicine.
2. Reasons for little uptake of services available in Health Centres.

### Education Component:

1. Reasons for children leaving school prior to completion of secondary education.
2. Reasons for children not enrolling, or not attending school.