APPENDIX

Exhibit 1

Table 30

Conducted Interviews RRA

Strata	Sex	Bengali	*Garo*
HCS-govt.	---	Not available	---
HCS-NGO	2 Male 1 Female	Doctor OPD ---	Doctor-manager Head nurse
HCS-traditional	1 Female	---	TBA
HCS-private	1 Male	Private practitioner	---
Education	1 Female 1 Male	 Teacher	Teacher
Politicians	1 Male	Union chairman	---
Administration	1 Male	Union secretary	---
Religious	3 Male 1 Female	Imam --- ---	Priest Priest Nun
Matabor	2 Male	Land owner	Land owner
Employee	2 Female 2 Male	Stamp vendor Pharmacist	Nurse Cook
Farmer	3 Male	Small farmer Small farmer	Small farmer -----
House wife	6 Female	House wife House wife House wife	House wife House wife House wife
Daily laborer	2 Male	Land-less laborer	Land-less laborer
13 Key persons 17 Villagers 30 Interviewees	18 Male 12 Female 30 Interviewees	12 Male 3 Female 15 Interviewees	6 Male 9 Female 15 Interviewees

Note. HCS-govt. = representative of the governmental health care services; HCS-NGO = representative of health care services provided by NGOs; HCS-traditional = representative of traditional healers; OPD = out patient department; TBA = traditional birth attendant.

Exhibit 2

Table 31

Time Table RRA

Activity	Date 1996						
Literature review	11/2	12/2	13/2	14/2	15/2	16/2	17/2
Draft outline data collection	18/2	19/2	20/2	21/2	22/2	23/2	24/2
Consultation & adaptations	25/2	26/2	27/2	28/2	29/2	01/3	02/3
Finalizing study design	03/3	04/3	05/3	06/3	07/3		
Flight Bangkok-Dhaka						08/3	
Consultation key persons							09/3
Interviews - observations - dialogues	10/3	11/3	12/3	13/3	14/3	15/3	16/3
Interviews - observations - dialogues	17/3		19/3	20/3	21/3		
Group discussion		18/3					
Flight Dhaka-Bangkok						22/3	
Consultation on analysis & reporting							23/3
Analyzing data[a]	24/3	25/3	26/3	27/3	28/3	29/3	30/3
Consultation and report writing	31/3	01/4	02/4	03/4	04/4	05/4	06/4
Consultation and report writing	07/4	08/4	09/4	10/4	11/4	12/4	13/4

Note. [a] The data analysis started during the data collection process, but the different analysis components were reviewed and composed to meaningful evidence.

Exhibit 3

Table 32

Interview Information Sheet RRA

Interview information sheet	Data collection *Garo* & Bengali settlements Madhupur
ID number	17
Date	16.03.96
Time start/end	10 a.m. - 11.30 a.m.
Place	Jalchatra
Name interviewee	---
Sex	Male
Age	34
Religion	Muslim
Ethnicity	Bengali
Place residence	Gathail
Occupation/position	Doctor OPD
Posted/work area	Jalchatra
Education	MBBS

Questionnaire

1. What do you feel is the most important concern/problem related to the well being (health = mental, physical, economic and social well being) of all villagers?

   .....Economic status.....

2. Please rank order the following list of concerns/problems related to community health. 1 = most important , 10 = least important.

Table 33

Closed Question RRA

Grade	Concerns or problems related to the well being of the community
2	Many people do not have sufficient food
9	Many people do not have proper housing
4	Most of the villagers do not have access to basic health care services
5	Villagers are not safe for natural disasters and crime
1	Many people do not have enough income for living
7	Family planning is not enough practiced among people
3	Villagers do not take action or participate in improving their own situation
6	Many villagers do not live according the values of the religion
10	Many people do not care for the environment (forest)
8	Many people can not read or write

Note. This is an example of a filled in questionnaire, during interviewing respondent number 17.

Table 34

Semi-Structured Questions RRA

Interview Guidelines	
Main questions	Supportive/probing questions
1. What is your main concern?	What do you mean by this? Why do you find this concern most important? What are the specific effects on the villagers?
2. Why is it that way?	What do you think are the reasons? Who is involved here? Who benefits from the situation? Who suffers from the situation? Who you feel is responsible?
3. What should be done?	What should be an acceptable situation? How could the problem be solved? What is needed to solve the problem in terms of money, manpower, training, materials?
4. Who should do it?	Who should take action? Who is in a position to take action? Who could mobilize these people? What could villagers do themselves?

Table 35

Comment Sheet Interviews RRA

Comment Sheet	
Time interview	10 - 11.15 a.m.
Emotional tune	Relaxed - interview in office - open minded - willing to go into depth.
Difficulties	No special problems - we know each other - certain phrases where unclear because of the use of high Bengali. Translator was useful at such moments - some limitation from respondent based on workload.
Own feelings	A very good interview - respondent had clear opinion on the issue. Was willing to elaborate whenever asked for. A rich source.
Insights/reflections	Underlying ideologies are equity - democracy - and spirituality. Convinced that spirituality among Bengali is the way to address problems in the society. Respondent is less clear about this for *Garo*. *Garo* people are pragmatic but with strong respect for religious leaders.

Note. An example of a filled in comment sheet from respondent number 17.

Exhibit 4

Figure 8. Bengali Translation Questions 1 & 2 Interview RRA

Exhibit 5

INTERVIEW NOTES				
Number	**Sex**	**Ethnicity**	**Strata**	**Concern**
15	Male	Bengali	Key	Health Care
WHAT? No access to HCS = people can not afford HC services = underminig health of cost winners = whole family suffers. Several unecessary deaths are caused by the present situation. If sick, people don't care (= have other priorities) when serious ill, they have to rely on the church because they have less access to HCS (= ignorance & can not afford).				
WHY? The main reason is ignorance. If sick they first wait & tolerate, then they go to traditional healers, then self treatment, when serious ill, the cost for care is high = no money, often they have to sell land to pay specialized medical services. Landlords and outsiders (non-tribal) benefit from this situation = loans with havy rent, sale of land agianst low rates, loans from landlords which makes them (villagers) more dependent. Villagers are the sufferers. Family and clan heads are responsible as well as matabors, besides the HCS which does not work properly (coverage, motivation, facilities, dedication HCW).				
WHAT TO DO? Basic health centers at village level, shelters for sich people. MCC and HE - preventive programs. Ultilization existing field workers - coordination and sharing experience. Dorgachola = 7 *Garo* villages = 1000 people next to Mandai, Muslim and Hindu. This are isolated and remote villages.				
WHO SHOULD DO? Joint effort of church & NGOs in health work in the village/do not expect the village to come to you.				

Figure 9. Interview Notes RRA

Exhibit 6

Table 36

Report Interview RRA

Report Interview		Concern: Income	
Number	17	Religion	Muslim
Name	---	Ethnicity	Bengali
Sex	Male	Strata	Key person

1. The main concern:
The low economic status of villagers is the most important factor because it determines health. Lack of income has a negative effect on all the other determinants affecting health as there are: food, education, initiatives, housing, clothing, religion and so forth. The effects of insufficient income are lack of nutritious and sufficient food, destruction of initiative, promotion of superstition and irrational behavior in dealing with disease, a deterioration of cleanliness, lack of sanitation and neglecting of education.

2. Why is it the way?
Unequal development and education not only between urban and rural settings but also within the rural setting. This widens the gap between the rich and the poor. Further there is the population pressure and the long history of political domination (by Moguls and the British) which had a negative effect on the community cohesion.
Everybody is a part of the process, dragged into a specific role. The rich become richer and the poor more numerous and poorer.

3. What should be done?
The responsibility for this situation is with the upper class. A society in which the rich/poor differential is low that is, 1/3 would be desirable. We need urgent a commitment to a social welfare state where there is justice in resource distribution. Education for all up to class 5 is urgent needed. Removal of the dowry system, which is a burden for families. Male and female should have the same rights in divorce matters. The country needs a responsible government which is committed to the common good.
The situation calls for a revolution on 3 levels: a cultural, a religious and a grassroots developmental revolution.

A cultural revolution to get rid of fatalism which is not a religious phenomena but the cultural end product of poverty, when real life situation teaches people that they can do nothing to change.
A religious revolution so that religious leaders become agents for developmental change. It would be a way to get away from externals. A commitment to God and men is a powerful factor in the Bengali society to initiate developmental change.
A grassroots development revolution where development agencies shift from taking action for the people to taking action with the people. Active participation is needed.

4. Who should take action?
Leaders and educated society members need to take action on condition that they not longer identify themselves with the upper class. A commitment to the poor is needed. Mobilizing people for real development should be done by the government but there is little chance this will happen. This country needs charismatic leaders. The NGOs should play a role in preparing the community for change.

5. Notes:
Verbatim: " *Garo* people do respect teachers and religious leaders but not a doctor. While if you see to Bengali, they have a lot of respect for a doctor. I wonder why *Garo* people not respect a doctor? Is the doctor a treat for their animistic or religious system? Once a priest told me that people do see God every where, but if medicine does not give place for God I its work, you can not expect respect."
Verbatim: "The spirituality of Muslim and Hindi people is a lot more developed than with the *Garo* people, because they where for long time exposed to main religions and cultures. Bengali are very intrinsic on spirituality. *Garo* people are not intrinsic in their spirituality and also less refined. For *Garo* spirituality is a mechanism to manipulate the reality".

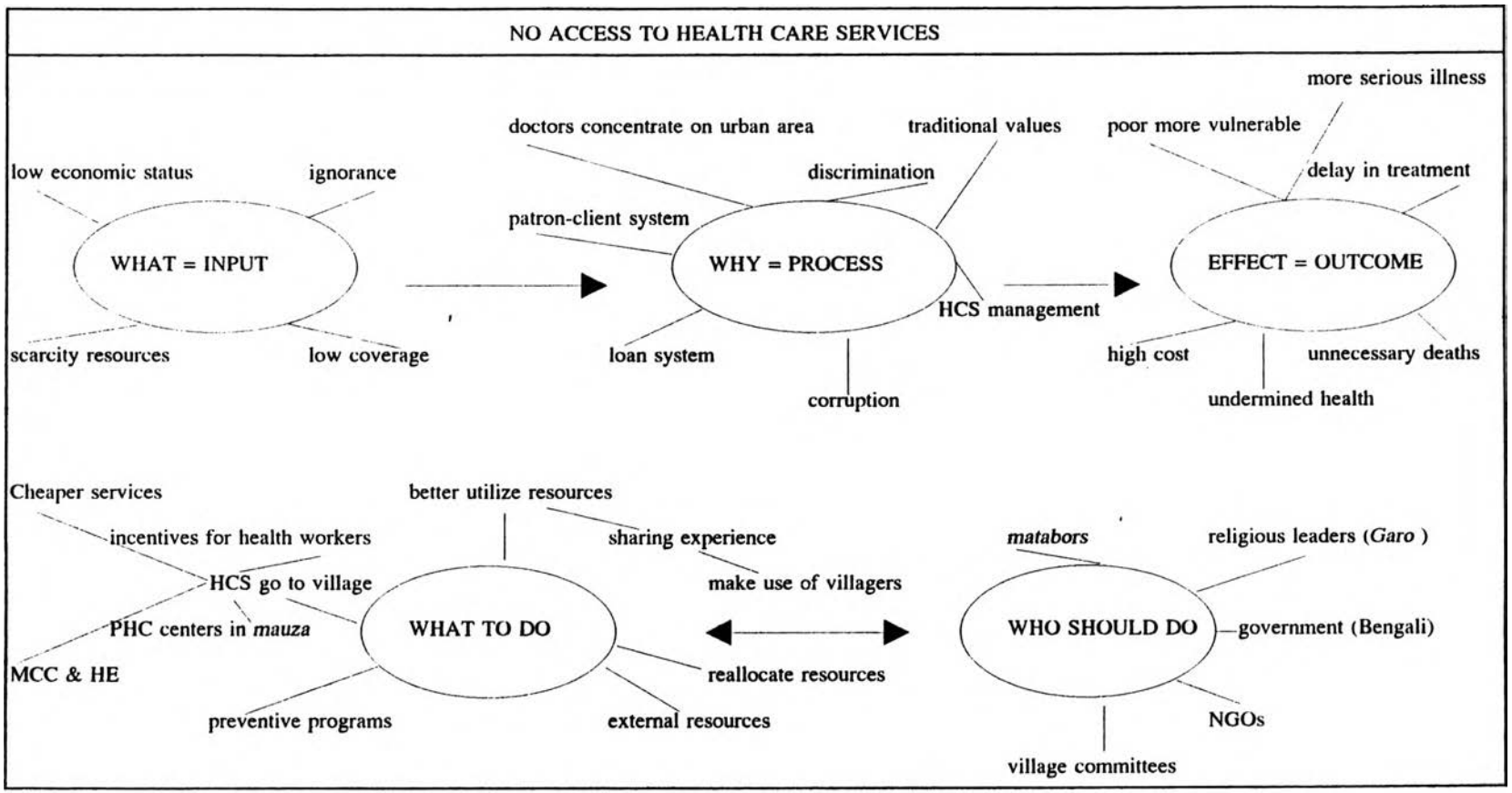

Figure 10. Mind Map and Causal Network for Analysis.
The respondents' viewpoint on access to the health care facilities.

Exhibit 7

Exhibit 8

Report on the meeting with Dorgachola villagers on 18.03.96

Present: 18 *Garo* - Christian, 4 *Mandai* - Hindu, 2 Bengali Muslim
Marc Van der Putten - evaluator (for detailed list, see exhibit 9).

Prepared by: Marc van der Putten
18.03.96.

Objectives of the meeting:

* Obtain a rough description of the village.
* Listing of problems seen from the villagers perspective.
* Come to an understanding of their expectations from govt. and NGOs.
* Check to which extend there is willingness to develop initiatives among villagers.

Selection of the site:

The village Dorgachola was several times proposed to me for taking action (research and development of programs) by the local religious leader. The selection of this village was based on his concern for the *Garo* community there, who live in a remote area, far away from basic facilities.

Report:

* *The group:*

Via the local religious leader and the *Garo* village headman the meeting was planned. Although I clearly expressed to keep the number of participants limited to 5-8 people and to have a representation of the different ethnic and religious groups, I ended up with 24 participants! The main ethnic and religious groups were present. I am grateful to the *Garo* village headman, who was able to manage all these people in no time. The emotional tune of the meeting was one of hopeful expectations to the 'outsider' who might be the key in finding solutions for their problems...

* *A rough description of the village:*

The village exists out of 7 *para* (sub-settlements) and is located at the border of 3 *thana* being Madhupur, Phulbaria and Gathail *thana*. The Dorgachola village is situated at high land which was previous a forest area, about 15 km from Phul*baria*, 22 km from Madhupur, 35 km from Gathail and 20 km from Sakhipur *thana* center (see exhibit 10 for a basic map). The main roads to the 3 *thana* are

under construction and it is expected that these roads will be completed by 1997. This will improve traveling to the centers of these *thana* by cycle, *riksja*, motorcycle and car, but the villagers need still to travel 1 to 3 km over small paths before reaching the main road. Only 1 *para* out of 7 has electricity supply from a parastatal supplier Poli-Biduth.

The different ethnic and religious groups settled *para* wise, and *para* are referred to as Mandi-*para* (*Garo*), Muslim-*para* (Bengali), *Koach-para* (*Mandai*-Hindu), Hindu-*para* (Bengali-Hindu) and so forth.

The village contains 150-200 *Garo* households (1000-1500 population), 150-200 *Mandai* households (1000-1500 population) 500 Bengali-Muslim households (5000 population) and 150 Bengali-Hindu households (1000 population). The overall population is estimated to be between 8000 and 9000.

All *Garo* households have drink water supply from tube wells, while the *Mandai* and Bengali still face an incomplete coverage. The same for water sealed toilets. The reason for *Garo* people being better of is that their church was very active during the last years with a water supply and sanitation program. *Mandai* and Bengali can apply for a tube well and toilet if they are interested.

The most close union health center (a governmental facility which offers a family planning program and very basic health services without admission) is about 5 km from the village, but a huge pool disconnect the villagers 7 to 8 months a year, during the monsoon season, from the health center.

The village has 3 primary schools being: 1 governmental, 1 missionary and 1 private primary school, further there is 1 *Madrassa* where Islam teaching is given and 1 missionary high school. The overall impression of the participants is that *Garo* people are better educated then the others. This due to a higher degree of motivation and stimulation, a better quality of teaching and the availability of a high school.

The village has further 1 Roman Catholic church, 3 mosques but no Hindu temple. There are besides 1 local pharmacy no other health facilities available at the village, nor private doctors.

There is a basic post office part-time operated by 1 villager.

Besides the Roman Catholic. church which is active in community development, there are 2 NGOs who have some activities in the village: Caritas which organizes income generating activities for certain groups and World Vision which has a scholarship program to promote education. Both NGOs have a Christian origin.

* *Listing of problems seen from the villagers perspective:*

Possession of land:

All participants confirmed that land troubles is a main head-ache. The area was originally forest area, while *Garo* people lived in the forest. After the deforestation, by outsiders mainly, *Garo* and *Mandai* people started to cultivate the land and many Bengali families arrived to settle as well. Formally the land is governmental property and all villagers without exception of ethnicity face problems with the forest police. Regular villagers face court cases and loose their cultivation land, which is the main source of income. The government claims the land for wood production purpose.

Irrigation problems:

The area is high land, so irrigation by deep tube wells is needed to cultivate the land. There are regulations on deep tube wells as: size of land and ownership. Also here villagers do face problems and can not consider deep tube wells because most do not fulfill the criteria. The result is no proper utilization of the land and low crop production.

Income:

Although farming is the main activity in Bangladesh, the Dorgachola villagers face low income from farming because of insufficient cultivation land, no access to deep tube well irrigation systems and the constant treat of land disputes with the authorities.

According the participants the majority of families in Dorgachola are daily laborers. The wages for daily labor varies between 20 to 40 Taka (0.5 to 1 US $) per day which is insufficient to maintain the very basic needs of a family.

The village nor the surrounding area offers job facilities, therefore many daily laborers have to find a job far away.

Communication:

The road infrastructure need to be improved. At present 3 secondary roads connecting Madhupur, Phulpur, Gathail and Sakhipur *thana* are under construction. This will improve the communication with the surrounding *thana* centers. but within a radius of 3 km from the village all communication remains the present network of paths only accessible for pedestrians, cycles or motorcycles. Once the secondary roads are completed, the main problem remains the distance from basic facilities.

Supply of utilities and sanitation:

The majority of the village has no electricity. This causes that most of the villagers are forced to restrict activities after sunset to essential things as meals and discussions by a kerosene lamp or candle light. Poli-Biduth, a parastatal agency for electricity distribution in rural area, could be approached to extend the supply lines, but villagers do need to group themselves and fulfill application criteria that is, a minimum fixed number of customers, and contributions in the required investment. The fact that houses are quite scattered does not make it easy to overcome the financial problems.

Water supply maintains a concern for many Bengali and *Mandai* households. The *Garo* parish council could play an important role to support the need of their neighbors towards the local religious (R.C.) leaders who do have a tube well program.

Water sealed toilets is also a need for most of the Bengali and *Mandai* villagers. Again here the *Garo* parish council could play a supportive role to meet this need.

Health care facilities:

The village has no doctor or nurse, there is no health center and no programs on basic health education and preventive measures are present. The government is supposed to offer vaccinations (EPI) for children and pregnant mothers, but the reality is that non of the villagers ever sees a governmental health worker visiting them.

The participants strongly expressed their need for primary health care facilities. Suggestions from some participants on medical ante-natal and delivery assistance, a mother and child care program, vaccination program, a basic health clinic, health education programs and emergency treatment facilities were confirmed by all participants.

Education:

Although primary schools are available and free of cost, participants expressed that many children face difficulties to continue education based on economic problems. The little scholarship program offered by World Vision is insufficient to meet the need among all villagers. *Mandai* and Bengali face more difficulties related to education.

Local job opportunities:
The only local opportunity to insure income is farming (with exception of the few teacher posts) whether on own farm or as daily laborer for some one else. Any other job has to be found far away from home. There is no local small scale industry.

* *Expectations from govt. and NGOs.*
All participants are quite critical towards governmental services. Verbatim: "Up to *thana* and even union level the government make plans, but we villagers never get anything". The government has little credit among the villagers. Everybody knows and experienced in one or another way the corruption within governmental services.

There is no formal communication between union level and village level, but informal contact is maintained. A disadvantage of these villagers is that the village area is located at the very end boarder of 3 different *thana*. This causes that they are not considered as important for each of these *thana*.

The *Garo* villagers can count upon their religious leaders to support community development. The *Mandai* and Bengali do not have such supportive structure and hope that NGOs will bring support from which their communities can benefit.

I had the impression that all participants, although prior explanation to the parish council chairman on the intention of my visit, had high expectations and hoped that my discussion with them would benefit them, especially in health related matters.

* *Is there willingness to take initiative among villagers for improvement of their situation?*
The *Garo* community is best organized for example, they have a parish council which is accountable to the main parish in Aronkhola union and the Mymensingh diocese. This parish council is the governing body for a number of sub-committees taking care for specific aspects of the community for example, education sub-committee, woman sub-committee, spiritual sub-committee and so forth.

Besides the *Garo* committees there are the Tribal Welfare Association and the *Mojid* committee of the Muslim community. These committees are less active and especially the Muslim *Mojid* committee focus on religious aspects of society life only.

Mandai and Bengali do not have such structured organization and remain dependent on the more classic cultural structure of '*matabors*' (informal village leaders) which are often the more rich and large farmers, who maintain the imbalance in the village system, advice and judge on village disputes and continue to ensure the position of the rich. One village can have several '*matabors*'.

Garo people are highly motivated to initiate activities for improving their quality of life and seek active help. An example of this was their need for a high school. Their religious leader agreed to assist them on condition that villagers were willing contribute by offering teachers without salary for a period of 2 year. Their church would assist in creating accommodation and provide a budget for the running cost on another condition: the school should be self reliant within a period of about 3 years. At present the high school is functioning and the school has 10,000 Tk. saved in the bank.

There is no regular cooperation and communication among the different groups (ethnic or religious) in the village. Only in case of need recognized by all groups, contact is established.

Reflections of the evaluator:

* *The group:*
The overwhelming majority were *Garo* participants (75%) against 16.5% *Mandai* and 8.5% Bengali. So the group did represent the local *Garo* community, but the representation of all specific ethnic and religious groups was not in line with the size of each specific group in the Dorgachola village. Although a very large group to deal with for discussion, about half of the participants were more supporter then active participant. The other half was spontaneous and active during discussion.

* *The village:*
I used different ways to reach the village and leaving the village, from the Phulbaria and the Madhupur *thana* respectively and the estimated distance from the center of these *thana* were correct, these *thana* or the only spots where public service facilities are available including hospitalization. There is a NGO hospital with a very limited number of general beds and a 24 hours emergency service at Jalchatra in Madhupur *thana* which is located 25 km from Dorgachola, the most close health facility with good basic services.

Indeed the village is situated at a remote area and unfortunately spread over 3 different first level administrative units. Further inquiry should offer an answer whether the entire village can not be taken care of for some public services by a single *thana*. This would offer an important improvement of the negotiation position of the villagers. Another possibility would be to split up the village into 2 to 3 single settlement. Each taking care for their own situation and dealing with there specific *thana*. 7 *para* is an unusual high number for a village.

The smallest administrative unit in Bangladesh is a *thana* (250 to 500,000 population). Each *thana* is divided into unions which are the smallest electoral units. For each union council their is an elected chairman and its members. A problem is that each union (about 35,000 population) contains a number of villages for which no formal structure is foreseen. So there is no formal representation of villagers and therefore the communication with the union council remains informal and is mainly based on the influence of certain matabors. If a village has a member in the council it will be better off. The same for villages who have an important *Matabor* with political influence.

* *Problems seen from the villagers perspective:*
The priorities among the representatives were: (1) the issue on land possession, (2) sanitation and water supply, (3) health care facilities and (4) assistance in agriculture. I would add (5) organization of the poor segments of the village, which is partially indicated above.

(1) issues on land possession:
Further inquiry is needed to understand the governmental policy and the concerns of the different parties involved. During my interviews I came across with the same problems and with some R.C. religious leaders who combat the human right aspect for *Garo* people. Possession of land is the economic source for living in Bangladesh.

(2) sanitation and water supply:
This is still a problem for *Mandai* and Bengali villagers. The R.C. religious leaders in assistance of NGOs from Christian origin solved this problem for the *Garo* community in Dorgachola. Negotiations could offer an answer on the question what could be done for the other villagers. The expertise is present, the points to be discussed are policy matters and financing or co-financing.

(3) Health care facilities:
This covers the whole range of primary health care services. A problem is that there is no coverage of public health services. Further discussion among villagers could reveal several solutions using local resources within the village especially for preventive activities. Further information is needed on the presence of traditional healers, village doctors and traditional birth attendants. Regarding curative health services the main need seems to be basic consultations and life saving emergency treatment, a difficult issue if we consider self reliance and sustainability.

* *Expectations from government and NGOs:*
Although all villagers as expressed by the participants face the same type of problems on possession of land, the tribal population will face more problems in other corners of public services due to discrimination at the political and administrative level. Throughout my interviews I regularly felt that tribal people do not expect any justice and fair treatment from the government, while Bengali people are well aware of the corruption it is a process among their own people and many consider it as a reality with one has to live. There is little meaning in fighting this issue. Maybe some improvement of the situation could be found if villagers come forward with constructive proposals for cooperation aiming at fulfilling their needs.

* *Willingness to develop initiatives among villagers:*
(1) The *Garo* people:
The local *Garo* community do have the benefit of the support of their active religious leaders, who try to support and answer the needs of the community from different perspectives that is, besides pure spiritual and metaphysical needs this leaders do address education, sanitation, water supply, land possession problems, agriculture, basic health care, income generating programs and so forth.
The result of this is that the *Garo* society is well structured, shows a better cohesion, and is reasonable well participating in addressing their problems. *Garo* people experience their religious leaders as trustworthy in good and bad times. The religious leaders are seen as their guides, supporters, in their fight to survive within the a discriminating environment.

(2) The *Mandai* people:
Ethnic different from *Garo* people and practicing Hinduism. They have their own identity and contacts with the other tribe (*Garo*) are minimum. In principle they face the same type of discrimination from the social environment as other tribal populations. Since this tribe was and is not the immediate target group for the R.C.

religious leaders, and in absence of other support, they made less progress in the development of their community. This results in a higher illiteracy rate, poor sanitation and water supply status and so forth.

(3) The Bengali people:
The majority population in Dorgachola, but mainly poor segments of the Bengali rural population. Bengali can be categorized as Muslim (87%) and Hindu (10%), but this religious identities are primarily a community concept, because the beliefs of the people vary so much and many of these beliefs do not accord with any Islamic nor Hindu orthodoxy (Abecassis, 1990). To be a Muslim is in Bangladesh is to be a part of the Muslim *'jati'* (community) and *'umma'*[*] (community of all Muslims) and is not necessarily a statement of faith, doctrine or world view. The elements of a Muslim rural village system are: the family (single or joint) settled in a *'bari'* (home = a series of houses), the *'gusthi'* the greater family clan following the male line descendants of one ancestor, the 'matabor' (village leader) leading a group within a village or a whole village, the *'samaj'* or the group of respected elders functioning as a village council. The *samaj* performs a religious function as well since its members are all attendants of the *jum'ah namaaz* (Friday prayers), and last but not least the patron-client relationships which are active on each level mentioned above (A. Rashid, personal communitcation, March 10, 1996).
The power structure in the village almost completely exclude both women and the poor. The richer men in a village, who are often leaders of the *samaj*, a *gusthi* or be a *matabor*, operate as brokers between the poor, who hardly travel outside their village, and the outside world, particularly the world of the government and local politicians. Therefore most of the resources available from governmental programs for the rural area came mainly to the rich and the bureaucracy. The power structure is in hands of the richer villagers and they use it to ensure the imbalance in resource distribution. The experience of powerlessness in face of these forces, has shaped the world view of the poor people together with the acceptance of *'jati'* thinking and the will of Allah. The corruption in the Bangladeshi society is so endemic and so deep that its presence is felt by the poor in almost all their activities. Corruption is actually accepted as the social norm.

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[*] *Umma* is the Islam world community.

Exhibit 9

Table 37

Participants Group Discussion RRA

Number	Function	Ethnicity	Religion
1	Union council member	Bengali	Muslim
2	Tribal welfare association	*Garo*	Christian
3	Parish council chairman	*Garo*	Christian
4	Farmer	*Mandai*	Sanatan Hindu
5	Farmer	*Garo*	Christian
6	Farmer	*Garo*	Christian
7	Farmer	*Mandai*	Sanatan Hindu
8	Retired teacher	*Garo*	Christian
9	Farmer	*Garo*	Christian
10	Farmer	*Garo*	Christian
11	*Matabor*	*Garo*	Christian
12	Farmer	*Garo*	Christian
13	*Matabor*	*Garo*	Christian
14	Carpenter	*Mandai*	Sanatan Hindu
15	Farmer	*Mandai*	Sanatan Hindu
16	Farmer	*Garo*	Christian
17	Teacher	*Garo*	Christian
18	Teacher	*Garo*	Christian
19	Teacher	*Garo*	Christian
20	Student	*Garo*	Christian
21	Teacher	*Garo*	Christian
22	Teacher	*Garo*	Christian
23	Teacher	*Garo*	Christian
24	Farmer	Bengali	Muslim

Note. Total: 18 *Garo* = 75% , 4 *Mandai* = 16.5% and 2 Bengali = 8.5%.

Exhibit 10

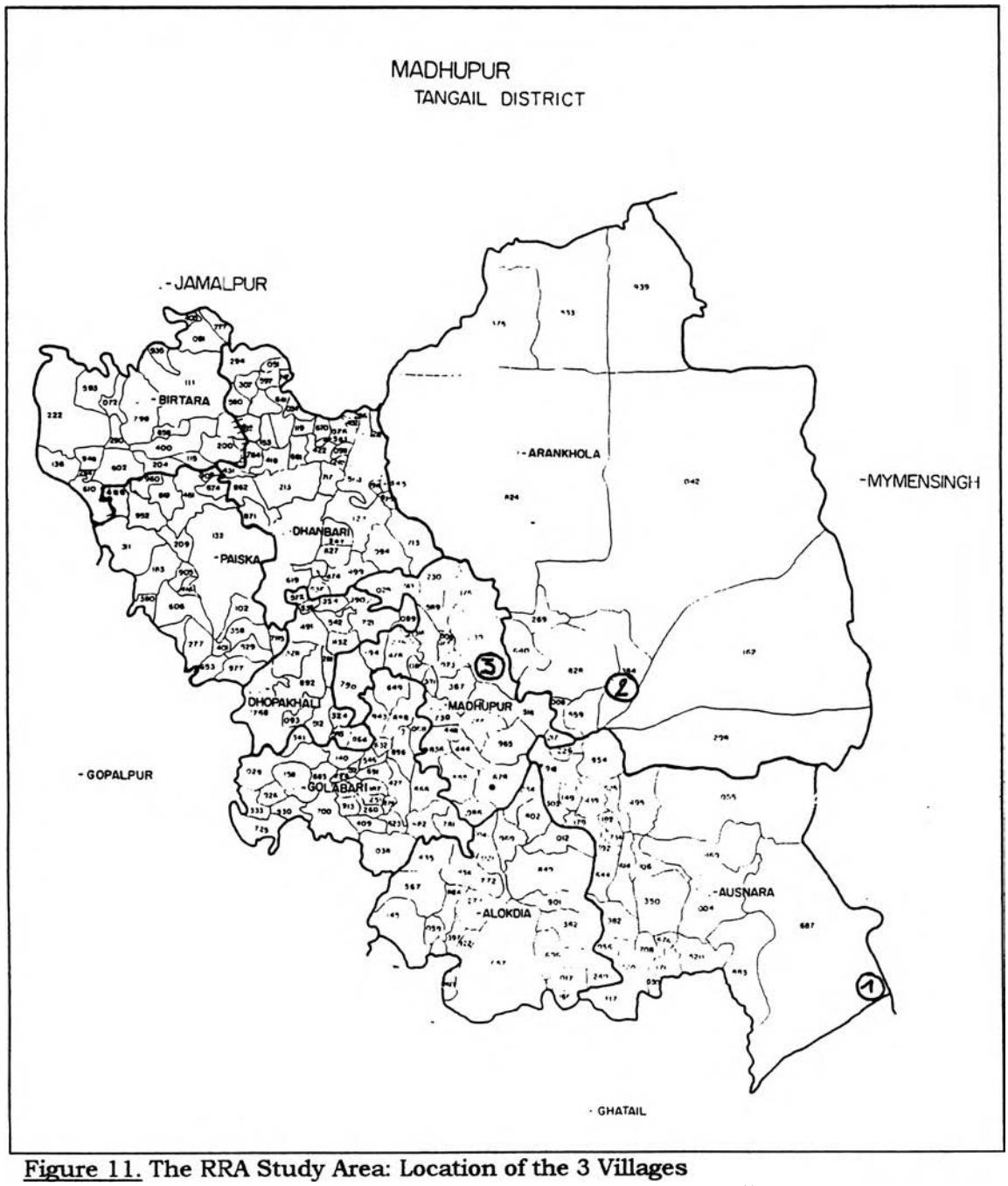

Figure 11. The RRA Study Area: Location of the 3 Villages
1 = Dorgachola village, 2 = Jalchatra village, 3 = Radhanagar village.

Exhibit 11

Set of Diagrams for Overhead Transparancies

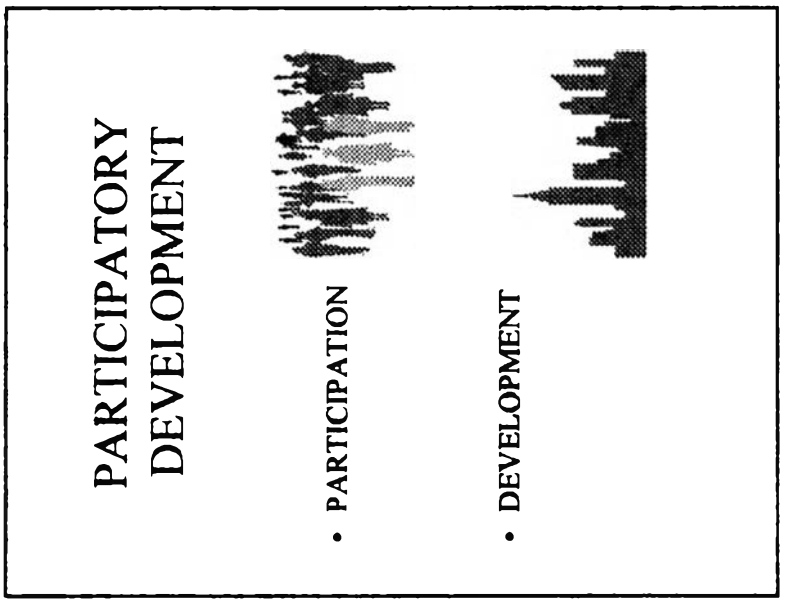

Figure 12. Participatory evaluation-1

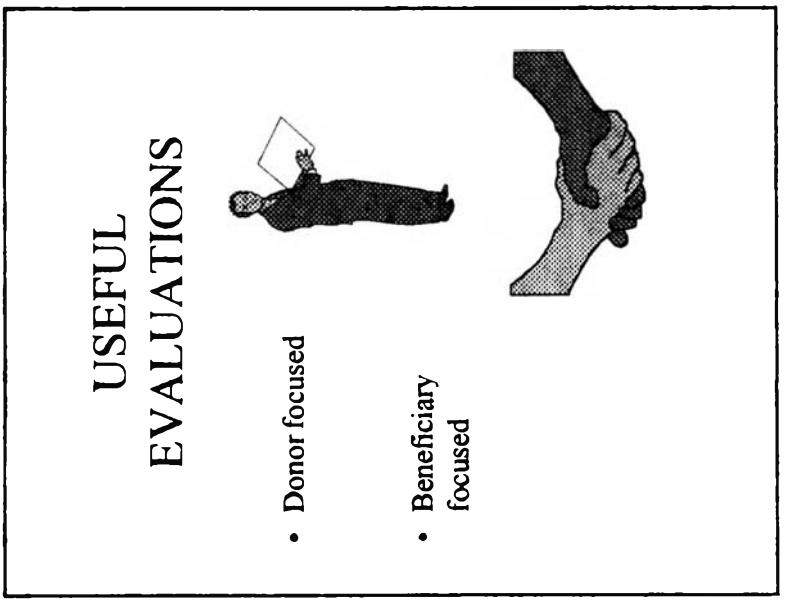

Figure 13. Participatory evaluation-2: Useful Evaluations

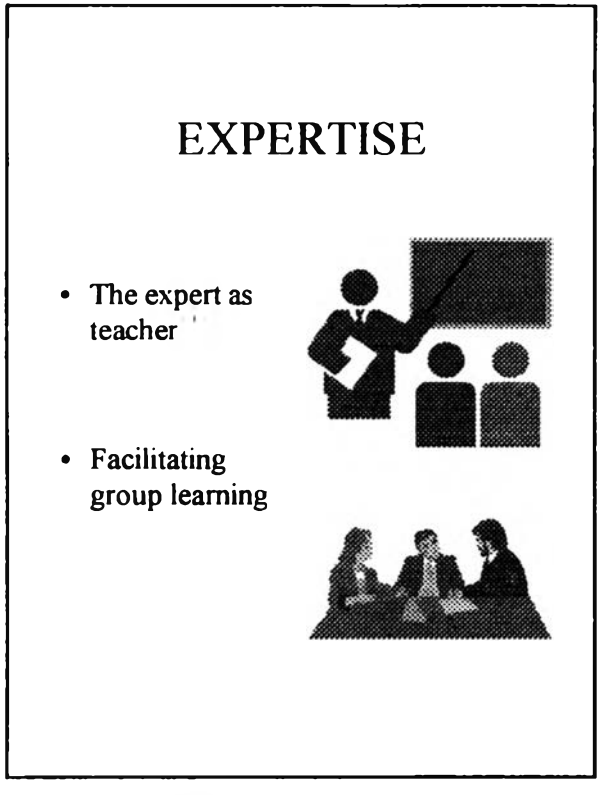

Figure 14. Participatory evaluation-3: Helping Projects Learn

Figure 15. Participatory evaluation-4: Expertise

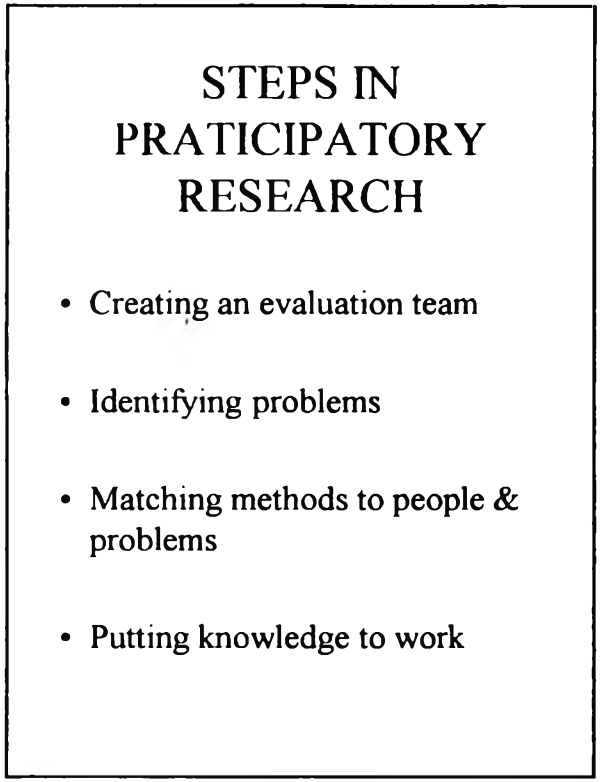

Figure 17. Participatory evaluation-6: Steps in Research and Social Action

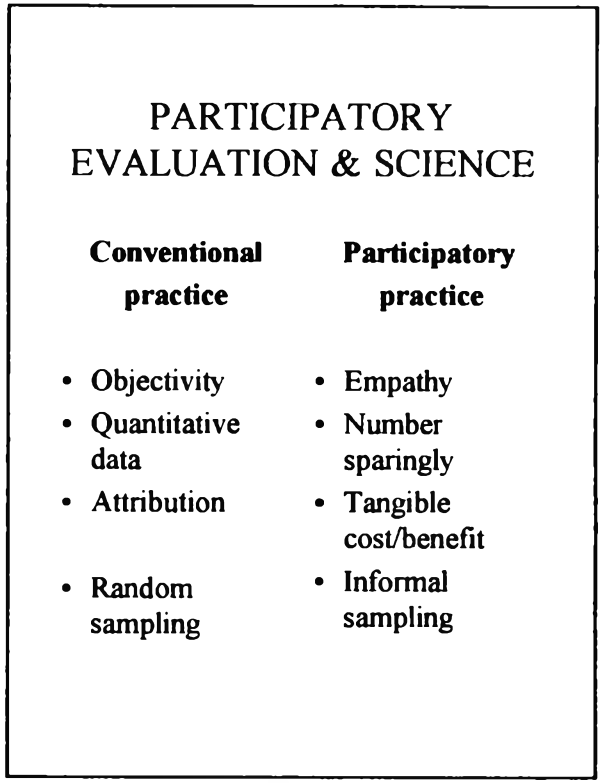

Figure 16. Participatory evaluation-5: Participatory Evaluation and Science

IDENTIFYING PROBLEMS

- Eliciting questions
- Open ended approach
- Framework approach
- Group dynamics

Figure 19. Participatory evaluation-8: Identifying Problems

CREATING A TEAM

- Old or new group
- Autonomy
- Group size
- Membership

Figure 18. Participatory evaluation-7: Creating a Team

PUTTING KNOWLEDGE TO WORK

- Common body of knowledge
- Spread information
- Converting ideas into action

Figure 21. Participatory evaluation-10: Putting Knowledge to Work

MATCHING METHODS PEOPLE & PROBLEMS

- Surveys
- Interviews
- Case studies
- Village mapping
- Group meeting

Figure 20. Participatory evaluation-9: Matching Methods with Problems and People

CURRICULUM VITAE

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Education

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1984 - 1987	Co-ordinator Psycho-Geriatric Care Verpleeghuis Mariahoeve KVV Stichting, The Hague, The Netherlands
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