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## Rapid appraisals for health: an overview

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### • Background

In the last few years, interest for collecting information that is obtained quickly and is reliable has been growing. Both for reasons of planning and cost, rapid collection procedures have gained popularity. Pioneered in the field of rural agricultural development in the so-called 'developing countries', these procedures might be defined as "any systematic activity designed to draw inferences, conclusions, hypotheses, or assessments, including acquisition of new information, in a limited period of time" (Grandstaff and Grandstaff, 1987).

Recently this concept has gained advocates in the health field. Interest has grown for several reasons. Certainly the main reason is the prospect of gaining information about the health problems of populations quickly and cheaply. Another important aspect, however, is the focus on the participation of the community in the information gathering exercises. This interest stems from the promotion of primary health care (PHC) in which community participation is seen as the key.

The last few years have provided an increasing number of experiences for health people ranging from the rapid collection of quantitative epidemiological data (*World Health Statistics Quarterly 1991*) to the gathering of information through qualitative anthropological/ethnological methods (Scrimshaw and Hurtado, 1987). In 1990, several international agencies including WHO and UNICEF convened a meeting in the United States to review some of these methodologies and their relevance to planning and evaluating health programmes. The

proceedings of this meeting are to be published soon.

As a further contribution to this area a meeting at the Institute of Development Studies, November 14-15, 1991 brought together a number of practitioners, researchers, and health care personnel to explore in more detail the potentials and limitations of the rapid collection procedures concept in the health field. Convened by Robert Chambers, participants included those attending an IDS seminar on planning primary health care, as well as aid agency personnel, members of the UK health service and university people.

At the onset, it is important to note in the health field that two distinct approaches have emerged under the umbrella of rapid information collection procedures. One comes from the field of epidemiology and has concerned itself with obtaining information about ill health and diseases. This has often been called 'rapid assessment' or 'rapid epidemiological assessment'. Its developers have concentrated around interests supported by the National Academy of Sciences in the United States and the Tropical Disease Research programme (TDR) of the World Health Organisation. In general this approach stresses rapid information gathering as a product of a specific and clearly articulated set of activities undertaken by health professionals using community people only as informants. (*Health Policy and Planning*).

The other approach, called Rapid Appraisal (RA) with more exacting titles such as participatory rural appraisal and rapid rural appraisal, continues to be rooted in the field of rural agriculture and rural development. This approach might be characterised as one, which stresses information gathering as a process and has developed a specific set of characteristics for data collection and analysis. These include:

- community involvement in information collection and analysis;
- holistic and systematic approaches;
- multidisciplinary and interactive methods;
- flexible responses;
- emphasis on communication and listening skills; and,
- development of the visualisation of information to replace only verbal communication.

In this approach the process is iterative, innovative, based on optimal ignorance, interactive, informal and in the field.

Both approaches, however, present an alternative to traditional data collection instruments which are longer implementing and are more structured and more detailed. Both have come to mean a quick collection of information at a low cost useful for planning at the local level.

This paper examines the RA approach and the issues it raises for health development. The objective of this overview is to identify some of the more important issues and discuss their implications for health RAs. While bias and value of information remains a concern, these are not the most important because users of RA attempt to recognise and confront these issues. Other issues are highlighted because they still are not so clearly conceived or articulated.

Although common with planning rural agricultural and development programmes, these issues develop different dimensions in the area of health including nutrition. Below, four major issues emerging from past experiences and critical to the use of RA in the health field are briefly discussed. These are 1) types of information collected, 2) community participation, 3) the information collection process, 4) information use.

## • Major issues

### Types of information

One major issue focuses on what information is collected. Rapid Appraisal recognises that only limited information on specifically focused topics is to be gathered. However,

there is the question about what type of information is most valuable - quantitative or qualitative? For planners who seek to make decisions about resource allocations quantitative information has been traditionally used. Only in the last few years has the value of qualitative information, particularly for use in programme evaluation, been recognised (Patton, 1990).

Many of the RA techniques emerging from the rural agricultural and development concerns produce mainly qualitative information. Their value to date has been to identify how communities look at different aspects of their daily lives. The techniques have not been designed to ask how many people have such views and beliefs.

In the past, in the health field, most health plans have been based only on quantitative information. Emerging from the scientific tradition of the search for 'objective' measures of health status and being dominated by the discipline of epidemiology, this view has resulted in a push for 'indicators' of health (Hansluwka, 1985). The indicators are seen as numerical representations of the health of a given population.

However, with the emergence of Primary Health Care which explicitly recognised less measurable factors, such as community participation as a key to better health, the supremacy of quantitative information for use in planning and evaluation has begun to be questioned. Planners, particularly those involved in programmes 'on the ground' have realised the value of information provided, for example, by key informants and focus group discussions. Many methods for obtaining this information can be found in the discipline of medical anthropology (Heggenhougen and Stone, 1986). Qualitative work of this nature based on personal interviews and researchers' observations is only just beginning to find recognition among those who plan and allocate resources on both national and international levels.

Still, health planners, particularly those with strong quantitative backgrounds such as epidemiologists and economists, struggle to accept the value of qualitative data. Their attitude might be summed up in this most

recent quote from the *World Health Statistics Quarterly*: “The qualitative rapid assessment methods, such as focus-group discussions, can complement quantitative methods by adding depth and insight but it may be dangerous to use them as a stand-alone method for policy makers” (Anker, 1991, p 97).

### Community participation

One main contribution of the rural and agricultural development field to Rapid Appraisal is the development of a toolbox of techniques for information collection. This issue of *RRA Notes* details some of the techniques and their uses in health. The techniques are based on participation of community people in both the collection and analysis of data. Yet, participation in the context of this exercise has taken on a variety of meanings.

In the health field, PHC has focused much of the debate on what ‘community participation’ means. WHO has recently published two monographs which explicitly address this question (Oakley, 1989 and Rifkin, 1990). Aspects of this question include whether community participation is a means or an end? what is active, as opposed to passive participation? are community people subjects or objects of the planning process?

RA contributes to the debate in some specific ways. It focuses on the need to explore the question of: how can active participation be ensured when the planners/professionals provide the conceptual framework for data analysis i.e. well-being ranking, matrix priorities, mapping? In other words, if the researchers/planners define the conceptual framework, what does community participation mean? There is a danger that it could be seen only as the provision of information for professionals/outside to use for decision making in which the community is not involved.

This leads to a corollary question, which is how can RA avoid becoming a manipulative process (whereby planners get and give selective information from communities), and become a participatory process whereby community people gain equal status with

professionals because of their knowledge and perceptions? RA has the potential to empower community people by both providing new information and, more importantly, validating information which they already have. A key to empowerment is the growth of dignity which comes from the ability to influence key decisions with knowledge internal to community people. This dignity most often comes with struggle for power and control of decision making mechanisms. RA has the potential to empower community people by both providing new information and, more importantly, validating information which they already have. A key to empowerment is the growth of dignity which comes from the ability to influence key decisions with knowledge internal to community people. This dignity most often comes with struggle for power and control of decision making mechanisms. RA has the potential either to support or impede this process. Planners/professionals must recognise this potential and act accordingly.

Finally, who owns the information and how can ownership be developed so the communities can use this to ensure their role in the planning process? Ownership of information helps or hinders the empowerment process. This process can only be supported when the community takes ownership. If the professionals/planners give ownership of information as a gift or a pay-off for the community’s participation, it endangers the empowerment process because the choice of ownership is not that of the community but of the outsiders.

The community role is critical to the development of rapid appraisal originating in the social/community tradition. It is the feature which distinguishes this approach from the rapid epidemiological approach. As with community participation in other health activities, however, there still is no agreement on the essential character and objectives of this area of concern. Focusing on the struggle and tension between control and empowerment, this state of affairs is likely to remain a major concern in the process of RA and, in fact, the whole development of health policy and action in the immediate future.

## The information collection process

Emerging from the questions surrounding the issue of participation is the more focused discussion about how information is collected. RA demands that information collection is a result of an exchange between professionals and lay community people. The quality of the information depends on the credibility established on both sides.

In the health field particularly, professionals are trained to see information as an end not the means of a process. Although health programmes and services are designed to benefit people, people are often treated as the means for getting the information.

RA has developed in the data collection methods, a mandate both to develop skills and attitudes which make professionals better listeners and which support lay people to be partners in the provision of information and decisions about how the information is used. By re-enforcing this type of exchange, professionals can be encouraged to be facilitators rather than inhibitors of community participation. This has implications.

Firstly, professionals need to become aware of the contributions of community people as sources of both information and insurance for programme implementation. Often, this means that situations for awareness building through direct experience with the RA methodologies must be created as few are convinced by merely reading articles. RA can create this environment and can generate support for professional re-orientation. For health planners, working in the community rather than the office, has in the past put them in touch with real situations and provided 'shock treatment' for rethinking.

Secondly, awareness needs to be supported by acquiring skills which enable professionals to work with community people. This means that training programmes must be established to teach these skills and engender new attitudes. Particularly important are communication and listening skills. The training aspect of RA is one which is critical to the promotion of community participation and PHC.

Thirdly, community people must acquire the skills and knowledge both to collect and interpret information. If they are to be more than passive informants, then they too must be able to handle information. Teaching and supervision is necessary. But most critical is support and confidence which can only be gained as a partnership between professionals and lay people is realised.

## Information use

The development of RA techniques in agriculture and rural development has focused on the process of data collection and needs assessment. It has rarely addressed the issue concerning how the information is used for planning a programme. In the health field there is a continual growing demand to link research with policy and action. An underlying theme in RAs undertaken by health personnel is fusing research with decision making. Two implications arise from this concern.

The first is the recognition of the need to build mechanisms to ensure support for a community role in programmes resulting from RA information gathering. These mechanisms include ways to ensure that lay people participate in the decision making process as well as the development of an accountability system between planners and communities. In an area like health where professionalism has so much respect, money and power, such mechanisms often flounder.

The second is the need to address directly the role of the professional in programme planning and implementation. Emerging from the power of the medical profession is the insistence of their role in controlling programmes and priorities. As a result, few health programmes have been able to establish strong partnerships between service providers and their designated beneficiaries. Only when mutual respect is established can control truly be shared.

- **Contribution of rapid appraisal to the health field**

Despite these unresolved issues, Rapid Appraisal has begun to make important contributions to the field of health policy and planning both in the developed and developing

countries. In addition to its attraction as a quick and cheap method for data collection, among the most important are the following:

### What information to collect

It has focused the dialogue on the debate about the value of quantitative and qualitative methodologies. Those involved in such exercises have begun to realise the contribution and limitations of both approaches and have sought ways to use both in developing their programmes.

### Community participation

It has developed techniques which have generated participation from lay people, particularly among the poorer communities, as a means to initiate their participation in planning processes and supporting their confidence in order to become subjects, not objects of health programmes.

### The information collection process

It has re-enforced the search to link information with decision-making, by enforcing the PHC emphasis on decentralised local planning through allowing those who manage programmes to collect the information. In this process, it has opened channels for local people to participate in both collection and use of information. As a result, programmes have the capacity to be controlled at the local level by a wide range of people including service providers and beneficiaries.

### Use of information

It has begun to develop training programmes that emphasis the development of attitudes among the professionals that enable them to act as facilitators, rather than dictators about community needs. Particularly, it has emphasised the need of professionals to develop good communication and listening skills and to recognise the value of experiences for those they are to serve. In this respect, it makes an important contribution to re-orienting health people toward Primary Health Care, the official policy of the member nations of the World Health Organisation.

## • Conclusion

Rapid Appraisal is likely to continue to be of growing interest to health people, both because of its focus on rapid information gathering and on community participation. In addition, as a training process, it facilitates the promotion of attitudes and skills which professionals need to do solid and productive community work. Its value in the health field will depend on whether the information it generates is seen to be of use to planners for purposes of both resource allocation and community participation. At worst, it has the potential to be a misused tool to collect poor information for supporting poor decisions and planning outcomes. At best it has the potential to give substance to the rhetoric of community participation by providing tools, techniques and information useful to planners and people to build a partnership for better health and health planning.

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