

1

Helping health workers to plan with communities in Ethiopia and Zambia

Karabi Bhattacharyya and John Murray

• Summary

This paper describes the use of a participatory approach to community assessment and planning in Ethiopia and Zambia. The purpose of the assessment was for government health staff and community members to jointly identify and prioritise maternal and child health problems and develop a plan to solve them. This assessment was conducted by a team of community volunteers and health staff. PRA and an integrated household survey were used to select a limited number of maternal and child health behaviours to guide planning and develop a joint action plan.

• Introduction

The recent issue of *PLA Notes* on Methodological Complementarity (Number 28, February 1997) highlighted some of the benefits of combining PRA with quantitative methods and sequencing methodologies. One of the benefits mentioned was the ability to provide planners with information that has scientific rigour for monitoring progress while collecting and using information that has local value. We have used a combination of methods to train government health staff to plan health activities with community members.

The design of the community assessment and planning process responds to two trends in public health planning. First there is a trend for primary health care programme planning to be decentralised to the district level, especially in Africa. Decentralisation requires that health planners collect local information to develop strategies and allocate resources. Second, as resources for health become scarce, poor

communities are increasingly asked to contribute resources (usually cash, land or labour) for health services. As a result, there is recognition, among some health planners, of the need to involve the local community in making programmatic decisions - deciding what is to be done and how.

While there is often the will to involve local communities in decision-making, health staff may lack the skills and tools needed, particularly for local level health staff who have with limited technical and financial resources. Health staff need assistance in a number of areas including: how to form groups which represent the community, how to engage in, and sustain, a dialogue with communities, and how to plan interventions with, and for, the people most in need.

The goal of the community assessment described here is for the health staff, and the communities they serve, to jointly identify and prioritise health problems and to develop plans to solve them. The assessment process collects and uses information on maternal and child health behaviours and is designed for district and sub-district program planners and health staff. The important features of this process are that it:

- uses a limited number of maternal and child health behaviours as a 'menu' to guide planning.
- uses an integrated household survey which measures indicators of the key behaviours.
- is conducted by a team of community volunteers who, with the health staff, are responsible for implementing health programs; it is not conducted by an outside research team.
- encourages community members and

health staff immediately to use and analyse information and to produce joint action plans.

- collects data that can be used at multiple levels: at the community level to develop an action plan and at the district and/or regional levels for project monitoring and evaluation.

• Design and methods

The process begins with a list of emphasis or key behaviours which have been shown scientifically to decrease the chance of children getting sick (morbidity) and dying from common illnesses (mortality). The list of emphasis behaviours are shown in Table 1.

Table 1. The emphasis behaviours

Health practice category	Emphasis behaviours
<p>Reproductive health practices: Women of reproductive health age need to practice family planning and seek antenatal care when they are pregnant</p>	<ol style="list-style-type: none"> 1. For all women of reproductive age, delay the first pregnancy, practice birth spacing and limit family size 2. For all pregnant women, seek antenatal care at least twice during the pregnancy 3. For all pregnant women, take iron tablets
<p>Infant and child feeding practices: Mothers need to give age-appropriate foods and fluids</p>	<ol style="list-style-type: none"> 4. Breast feed exclusively for about 6 months 5. From about 6 months, provide appropriate complementary feeding and continue breastfeeding until 24 months
<p>Immunisation practices: Infants need to receive a full course of vaccinations; women of childbearing age need to receive an appropriate course of tetanus vaccinations</p>	<ol style="list-style-type: none"> 6. Take infant for measles immunisation as soon as possible after the age of 9 months 7. Take infant for immunisation even when he or she is sick. Allow infant to be immunised during visit for curative care 8. For pregnant women and women of childbearing age, seek tetanus toxoid vaccination at every opportunity
<p>Home health practices: Caretakers need to implement appropriate behaviours to prevent childhood illnesses and to treat them when they do occur</p>	<p>Prevention</p> <ol style="list-style-type: none"> 9. Use and maintain insecticide-treated bednets 10. Wash hands with soap at appropriate times 11. For all infants and children over 6 months, consume enough vitamin A to prevent A deficiency 12. For all families, use iodised salt <p>Treatment</p> <ol style="list-style-type: none"> 13. Continue feeding and increase fluids during illness: increase feeding after illness 14. Mix and administer Oral Rehydration Salts (ORS) or appropriate home-available fluid correctly 15. Administer treatment and medications according to instruction (amount and duration)
<p>Care-seeking practices: Caretakers need to recognise a sick infant or child and need to know when to take the infant or child to a health worker or health facility</p>	<ol style="list-style-type: none"> 16. Seek appropriate care when infant or child is recognised as being sick (i.e. looks unwell, not playing, not eating or drinking, lethargic or change in consciousness, vomiting frequently, high fever, fast or difficult breathing).

The emphasis behaviours are used as a 'menu' from which communities and health workers jointly prioritise those behaviours that are most important and feasible to change (see below). The prioritised behaviours form the basis for a joint action plan. The methodology is conducted over a 8-10 day period in each community. The four phases used are:

Phase 1: Identifying partners and building partnerships emphasises the establishment of working relationships between the health staff and community team members. The health staff are introduced to the community through a public meeting. The community learns that the team is there to listen to them and draws a map of the area and lists their own health priorities.

Phase 2: Selecting the emphasis behaviours involves the use of a simple household survey which collects information on the key child health behaviours in a sample of households. Cut-off points of 80% were established for the behaviours by the health staff. This meant that if less than 80% of people were undertaking the behaviours, they were considered to be at unacceptable levels. The team tabulates the data by hand. The behaviours shown to be undertaken by less than 80% of those people consulted in the survey are ranked, by groups of men and women, according to the importance of the behaviour and the feasibility of changing it. Based on the community ranking, 3-5 priority behaviours are selected.

Men and women are selected to be part of the groups if they have a young child or are involved in child care. Every attempt is made to promote participation from all segments of the community. For example, the social map from Phase 1 is used to ensure that different geographic and socio-economic areas are represented. It is particularly important to ensure that women with different backgrounds are represented; women who have to work, who have less education, and who are single mothers, for example, may all present unique perspectives. Women's and men's groups meet separately and are made up of 5-10 persons each.

Phase 3: Exploring reasons for the behaviours involves the use of a variety of participatory research techniques, including semi-structured interviews, seasonal calendars, and matrix

ranking, to explore the reasons behind the practices of the 35 selected behaviours. For each behaviour, a list of suggested topics and methods for understanding the behaviour more fully is used.

Phase 4: Developing intervention strategies based on the reasons why people are not undertaking the selected behaviours. The intervention strategies are suggested by community members and the health staff. During a public meeting, an action plan is developed for implementing the strategies. The action plan includes the identification of resource needs and allocation of responsibilities.

Field testing

In Ethiopia, the process was conducted in five districts in the Southern Nations and Nationalities People's Region (SNNPR). Ministry of Health staff from the regional level, four zones and the five districts were trained in the methodology for one week. The group then broke into five teams who went to selected communities in the five districts for an 8-10 day period to complete the four phases. The size of the communities ranged from 726 to 1187 households. At the end of the fieldwork, the group came back together to develop detailed implementation plans and identify next steps.

In Zambia, the process was conducted as a training of Ministry of Health staff for two weeks. It included 7-8 days fieldwork in two communities with a total of about 65 households in Chipata district, Eastern Province. A total of 14 people were trained including health staff from the national level, three districts in the Eastern Province, and staff from one health facility.

Community action plans

Communities and health staff were encouraged to develop action plans that were feasible given existing resources and structures. In general, the activities focused on the household (the knowledge and behaviour of caretakers), the broader community (support required to sustain or enable household behaviours, such as the availability of soap or community health workers) and the health

facility (health worker knowledge and practice, the availability of medications).

The strategies developed by communities in both Ethiopia and Zambia had a number of similarities. Community members were often not able to get vaccination or antenatal services and so it was proposed that better integration of services would reduce missed opportunities for immunisation and antenatal screening (e.g. checking the vaccination status of mothers and children during visits for curative care). Improving the counselling and health education skills of health workers on several key primary health care topics was considered very important.

Within communities, improved community organisation and participation was considered important to support household behaviour change. It was proposed that community-based health workers and community groups should be encouraged to conduct health education and motivate community members to seek services. Most communities wanted to involve existing community groups, such as churches, mosques, women's associations and schools, in health work. For example, some women said that their older children who were at school sometimes reminded them to take their infants for immunisations. Some community members expressed a need to develop new groups, such as health and nutrition groups.

The need to develop incentives for community health workers was raised in all communities and considered essential to sustain their performance. Community groups discussed the development of revolving drug funds, or central community funds for supporting community health workers, as well as non-monetary incentives such as regular training, and the provision of farming assistance for community health workers and their families.

Lessons learned

We have found that it is important to be clear on the features and limitations of this process (see Table 2). First, this approach is not intended to produce broad community participation or empowerment. Rather an attempt was made to be aware of existing power relationships in communities and to identify and involve the most vulnerable groups. However, it should be noted that this process is unlikely to change those relationships.

Second, the one-off implementation of this approach is unlikely to produce sustained changes in how health staff interact with community members. On-going training and supervision will be necessary for this to occur.

Third, since only limited data are collected, this approach does not allow the investigation of the complex socio-cultural aspects of each behaviour, such as a local understanding of diarrhoeal disease. Instead, data collection is focused on information that can allow sound program decisions.

Finally, this process is not a 'blueprint' or recipe for health planning. The 'menu' of behaviours, the specific methods used, their sequence and timing (whether over 10 days as done here, or over a longer period of time) must be modified and adapted to local situations. For example, there is no guarantee that drawing a social map and holding a public meeting will create rapport and generate a sense of partnership. However the goals of each of the four phases (building partnerships, selecting behaviours, exploring reasons for the behaviours, and developing an action plan) should help guide the key steps in the process.

Table 2. The community assessment and planning process

Does not ...	Does ...
Change existing power relationships within a community	Teach health staff to learn and listen from community members
Create sustained changes in the attitudes and behaviour of health staff towards communities	Give communities and health staff boundaries and a focus for the discussions (emphasis behaviours)
Produce in-depth information on cultural belief systems on any of the behaviours.	Use the emphasis behaviours as a way to open up discussions of constraints (cultural, social, environmental)
Produce quantitative data that is generalisable beyond the communities where it is collected	Use data and community priorities to decide health activities
Constitute a blueprint for better health planning	Begin a better relationship between health staff and communities

On a more positive note, this approach does represent a change in local level health planning. Currently, most program decisions are made without using local data and without any community involvement. This process helps health staff develop concrete skills for collecting and using data with community members. The use of emphasis behaviours worked well because maternal and child health issues were an important priority in these communities, although not always the top priority. Simple quantitative and participatory methods, which can be implemented quickly with a minimum of resources, make this process accessible for local health staff.

The emphasis behaviours provided a focal point for planning, but the suggestions for changing these behaviours were not only limited to individual behaviour change issues (such as health education to mothers). They also highlighted the need to address the organisation and resources of the community itself and to improve the quality and accessibility of care available at health facilities. As a consequence, health staff were made aware of the impact of their own policies and practices on members of the community. In this way, this assessment and planning process began to change the relationship between health staff and community members.

- **Karabi Bhattacharyya and John Murray**, Basic Support for Institutionalising Child Survival (BASICS) 1600 Wilson Blvd., Suite 300, Arlington, VA 22209, USA.

ACKNOWLEDGEMENTS

Thanks are extended to Dr.Estifanos Biru and to Ministry of Health staff who participated in this assessment: Leul Seged Asfaw, Abu Awol, Sr. Workenesh Kereta, Kassahum Belete, Tomas Toina, Paulos Amenta, Getachew Assefa, Kekebo Debake, Ashenafi Argeta, Dr. Solomon Worku, Tirfe Mesfin, Belay Roma and Dr.Tekeleab Kedamo. Thanks are also extended to Drs. aul Freund, Mengistu Asnake and Mulageta Betre and Mr. Wondimu Amdie of BASICS Ethiopia and Dr.Peter Winch of John Hopkins University for assistance with the conduct and further development of the assessment. The support of the USAID/ESHE project in Ethiopia and the contributions of Ms.Melissa Woods, Dr.Carmela Abate and Ms.Carina Stover are acknowledged with thanks. Finally we thank all the community members who took the time to teach us. BASICS is funded by the Office of Health and Nutrition of the Bureau for Global Programs, Field Support and Research of the U.S. Agency for International Development (USAID) – contract number HRN-6006-C-00-3031-00

NOTES

For a complete discussion of emphasis behaviours, see 'Emphasis Behaviours in Maternal and Child Health: Focusing on Caretaker Behaviours to develop Maternal and Child Health Programs in Communities', BASICS Technical Report, 1997.