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### Health

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#### • **Report of Rapid Appraisal trial, Mbeya, Tanzania**

This is a report<sup>1</sup> of a rapid appraisal (RA) of health problems in Mbeya, Tanzania. The workshop was divided into three phases:

- introduction to the methodology;
- data collection; and
- formulation of a plan of action.

Fieldwork was carried out in three wards chosen by the municipal medical officer. All three wards were squatter areas. Two were areas of high concentration of population. The third was a peri-urban ward in which the main source of income was still farming. In addition, this ward had key officials who lived some distance from the area and thus had limited contact with the residents and their problems. As a result, this ward presented problems not encountered in the two more urbanised wards and posed different challenges for the rapid appraisal methodology.

#### **Workshop methodology**

It was explained that:

- RA was based on three sources of information-documents, key informant interviews and observations.
- is undertaken by professionals in multidisciplinary teams in order that various aspects of information about one

subject can be explored and experiences can be applied to judge the importance of the information presented.

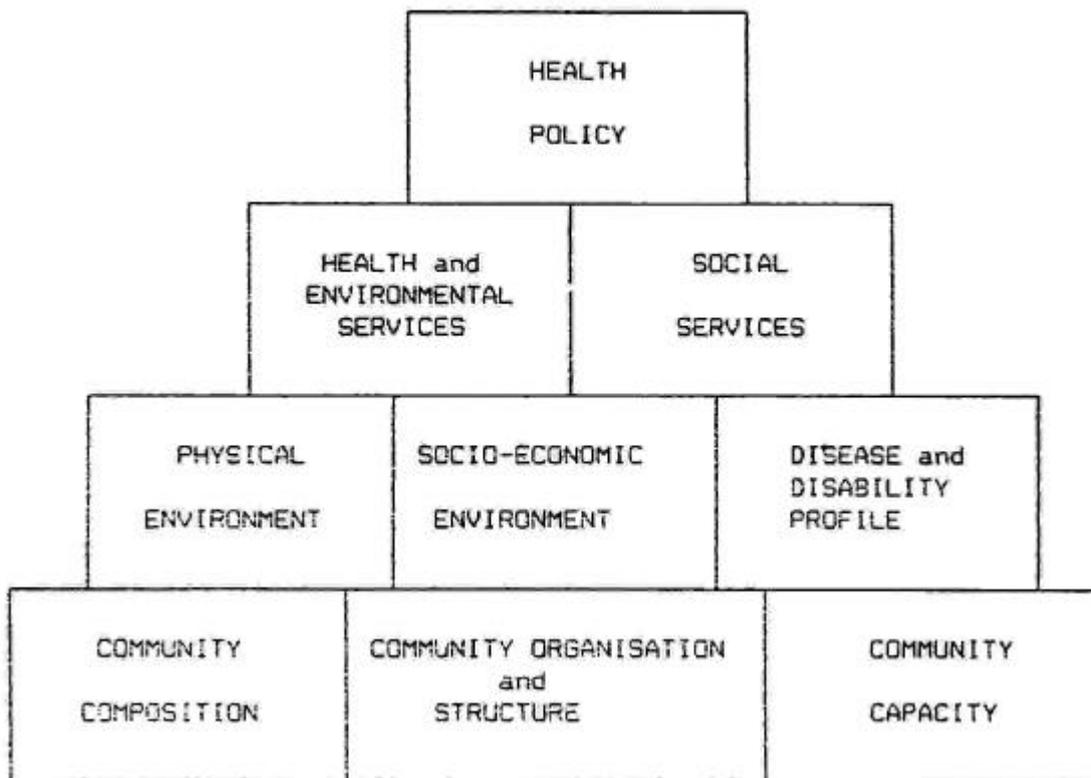
- RA is not merely a method for collecting data about the health problems of the urban poor but, more importantly, a process by which to make a plan of action to improve the living conditions of the people based on the participation of these urban residents in defining their own problems.

The idea of using a planning profile in the shape of a pyramid as a means of identifying important areas for which information needed to be collected was presented. Participants were told that the blocks of information which made the pyramid were collected from the three sources mentioned above. To illustrate graphically this approach participants were asked to write information collected from documents on yellow cards, from key informants on pink cards and from observations on green cards.

The recording of information on the cards and placing them in the categories of blocks of the planning profile provided the basis both for the recording of information and the analysis.

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<sup>1</sup> The methodology is described in the document 'Guidelines for Rapid Rural Appraisal to Assess Community Health Needs: A focus on Health Improvements for Low Income Urban Areas'.

**PLANNING PROFILE**

The planning profile was explored in detail. Participants were divided into three teams composed of members from different sectors. Each team brainstormed on questions which needed to be asked to build the blocks of the pyramid. Using white cards, they wrote the questions down and each was read, placed in the appropriate block of the pyramid (which had been drawn on large sheets of white paper and attached to a blank wall), then grouped together around specific issues. These groupings provided the basis for the categorisation of data and included health policy, health and environmental issues, social services, physical environment, socio-economic environment, disease profile, community composition, community organisations and structure and community capacity for self-help. Participants then identified from which sources these questions might best be answered.

Based on the categorisation of data in the planning profile a checklist of information for

interviews and observations was developed. The checklist reflected a choice of information based on discussions about each item. The entire group also considered which people might be key informants. A list was compiled and written on white paper.

Finally participants looked at documents as a source of information to answer some of the questions which had been previously identified. Each participant was asked to bring from his/her office documents which would help to identify health problems. Each team was assigned to draw from the documents general information on Mbeya.

In preparation for data collection by semi-structured interviews and observation the checklist which was prepared on the second day was recorded on the first pages of a notebook given to each of the participants. On the front cover of the notebook information was recorded which reminded participants about how to open interviews, how to record

notes, how to conduct semi-structured interviews in teams and how to end interviews.

### Data collection and analysis

The first field visit was by pre-arrangement to three wards selected by the municipal medical officer. Each team went to the wards, met the ward officials and presented the reasons for the interviews. Assistance of the officials was asked for obtaining interviews with other key informants. In the meeting with ward officials, information was collected from them about health problems. However, ward officials comprised less than one quarter of all ward interviews.

Much time was given to key informant interviews. On returning the teams identified the major health problems in the three wards. Each ward had different problems analysed by these professionals based on key informant interviews, observations, documents and their own experience. Participants then reported in plenary the answers to the following questions:

- What were the major health problems?
- Who told you about these problems?
- Did your observations confirm these problems?
- Do the documents suggest that these are the problems?

However, when the problems were analysed, it was realised that no priority had been given to them. It was thus arranged for teams to return to the field to ask key informants to rank the order of priority of the problems they had identified.

Each key informant was given 8-10 cards with the name of one identified problem on each card, then asked to rank these cards according to the most important problems. Blank cards were provided in case a problem was identified which had not earlier been recorded. Health priorities were then compiled for each ward. The teams then suggested solutions to these problems.

A matrix was introduced by which to rank the feasibility of the recommendations in order to place priorities on which was to be undertaken first. The method was illustrated by asking each team to choose one possible

recommendation for the ward it surveyed and to judge its feasibility by the following criteria:

- health benefit (what was the overall health impact?)
- community capacity (how committed was the community to solving the problem and what could they contribute to its solution?)
- sustainability (would the intervention be able to be maintained and at what cost for maintenance?)
- equitability (which income groups were likely to benefit most?)
- cost (what are the initial capital and manpower costs?)
- time for benefit (how long would it take before changes would be noticeable?).

Each recommendation was scored in these categories by giving '+' for low, '++' for medium, and '+++' for high. The highest score was given the highest priority.

### Assessment of methodology: views of the participants

In general, comments were positive and enthusiastic. Positive experiences included:

- Discovering aspects of community life which were unknown to each before the investigations;
- Working in multidisciplinary teams to contribute to and draw upon experiences from other sectors; and,
- Using semi-structured interviews instead of questionnaires to discover community problems.

There were however some difficulties with the approach. The following needs were highlighted:

- The need to overcome the bias of the sample.

Because of possible bias, it was noted that it was important that ward official interviews comprised less than one-quarter

of total key informant interviews, that interviews were undertaken both in focus group and in individual situations and that interviewers be constantly aware of these possible biases. It was felt however that bias could be limited if key informants were carefully selected. It was suggested that in the future more time be spent in identifying key informants.

- The need to overcome the shortage of time.

Time was not sufficient to complete the planning process. A ten day workshop would be the minimum to come up with some solid recommendations.

- The need to overcome problems of interviews.

Participants felt that the lack of experience of how to do semi-structured interviews was detrimental to the collection of data. They suggested that a pilot interview be undertaken to give them some experience in these methods.

## Conclusion

It appears to us the approach developed in the guidelines provides a solid basis for programme design and development. It also has the advantages of gaining community dialogue at the very early stages of programme planning to build a basis for negotiation and partnership between the resource holders and beneficiaries. As indicated, the use and validity of the approach to improving the health of the urban poor will depend in great part on the interest and commitment of the authorities to deal with the complex problems in slum and squatter area. Adaptations to individuals' situations will of course have to be made. However, the general approach appears to be both acceptable and useful to municipal planners in their search to deal with the problems of the urban poor.

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## • Rapid Appraisal South Sefton (Merseyside) Health Authority

March - June 1989

1. The introduction of Locality Management in South Sefton raised questions about the assessment of need of the population served by the District Health Authority. Traditionally needs have been indirectly assessed through the use of health indicators. However, with the advent of more consumer-orientated thinking the qualitative approach has to be considered as a crucial option in understanding user's perspectives on health and health services.

Community development approaches, particularly in Health Promotion, have focused on users' perspectives, but the methods of work tend to be labour-intensive and small scale. The main problem has been how grassroots ideas can be fed into the planning and policy setting process. Furthermore, how can local concerns be translated into action when organisations such as the Health Service tend to be centrally controlled. Rapid Appraisal (RA) provides some solutions to the above questions.

2. The choice of RA in South Sefton was informed by the decision to 'go local' in management and provision of service. This opens up opportunities to involve local communities in diagnosis of health priorities, and thus identifies for Locality Managers key people who can participate on a longer term basis in the health planning process. It also has benefits in creating a baseline for regular follow-up RA exercises, assessing progress in service development as seen by the users.

Building relationships with a community is important for managers who are committed to bottom-up planning as they can create more permanent forums for debate through RA. In South Sefton, RA is seen as the first step to involve communities in planning and evaluating health services. The managers carrying out RA are capable of translating communities' views into workable policies

and practices, and through the RA mechanism will be accountable to the community.

3. The RA exercise in South Sefton was based upon the WHO document 'Guidelines for Rapid Appraisal to Assess Community Needs: a Focus on Health Improvements for Low Income Urban Areas'. The authors of the document planned a two-day workshop with the Manager of Research and Development in Sefton, who had secured participation of a variety of managers.

From the Health Authority:

- the Director of Nursing Services, Community, Elderly and Mental Handicap;
- the Director of Nursing Services, Mental Health;
- the District Health Promotion Officer;
- the Operational Planning Manager; and,
- the Manager of Research and Development.

From other agencies:

- a Principal Housing Officer;
- the Deputy Administrator of the Family Practitioner Committee;
- the Planning Officer of Social Services; and,
- the Research Officer of Social Services.

The workshop took place on March 16th and 17th 1989. The first day and a half was devoted to formulating questions relating to the information pyramid as described in the document. The managers in South Sefton could not be released for the required ten days, and the interview programme had to accommodate this. Instead, a timespan of eight weeks was agreed in which all the interviews and preliminary analysis would be completed.

The District Health Promotion Officer and a Nursing Officer who were both knowledgeable about the ward to be

investigated (Linacre ward in Bootle) drew up a list of names of key informants. Three multi-disciplinary subgroups were then allocated a mixed group of interviewees and arranged their own interviews. One intermediate working meeting was planned to assess progress.

The subgroups carried out almost all their interviews within the set period and did preliminary analysis on the data they had collected as a group. A one-day workshop was held on May 18th to analyse the total data set, and clearly defined issues were highlighted. These were 'reduced' to one-line statements and then ordered into the separate categories. Each statement was typed into a colour-coded card to be presented to the informants for placement into priority order. Subsequently a final meeting was held to complete the analysis of the data and prepare a plan of action.

The information pyramid was found to be equally relevant in the Sefton situation as in the Third World. However, emphasis on data collection should shift mainly to interviewing and observation, rather than gathering documentary evidence. Health planning in the developed world is heavily based on quantitative data, but in contrast to underdeveloped countries, this data is so abundant that planners are struggling with turning this into information rather than having to search for data. This, therefore, poses the problem of losing sight of what the population for whom services are planned actually want themselves. In using RA, the investigators became aware of the need to re-focus their attention on collecting qualitative data by listening to the community.

The interviews themselves went very well, because the co-operation of all interviewees was good. The three teams were very enthusiastic about talking directly with the community about their perceptions of priority problems. As managers they had only indirect contact with people who (potentially) use their services and the RA interviews made them feel 'in touch' again. Furthermore, they gained new insights into the complexity of causes of ill-health as they were explained to them in terms of the socio-economic

and cultural fabric of Linacre ward. On the other hand, certain findings confirmed what was known already.

An additional benefit was the truly multi-disciplinary nature of the investigative work itself. Rather than sitting together *in* joint planning meetings, managers were out actually working together, getting to know each other, sharing information and analysis.

It is too soon to evaluate the success of the exercise in leading to joint action for health in the ward. However, this is being monitored and a paper on the exercise is now being prepared for publication.

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