

## **29. Rapid appraisal to assess community health needs: A focus on the urban poor**

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**This paper considers some rapid appraisal techniques from an organizational perspective and how they are used to develop a more rapid form of data gathering for use in urban areas. The paper lays out a series of specific steps which were tried in several circumstances with assistance from WHO. Of interesting note is the report that these guidelines were found useful in Bangladesh, Tanzania and also in an urban area near Liverpool in the U.K.**

**The success of this approach will be further judged by its use, particularly if other researchers continue to be self-critical and document issues related to their work. - Eds.**

ONE OF THE major problems for planners is collecting data on which to base programme design. In the health field, national and local plans have often been tenuous, as data are either non-existent or too unreliable. This is particularly true in developing countries because of the scarcity of data collection infrastructures and the lack of professionals to collate and analyze the data. It is even more difficult to overcome this problem of scarce data in urban squatter and slum areas where migration leads to unstable populations and lack of legal land ownership, making people very reluctant to "stand up and be counted."

Data collection is also complicated by the fact that it is often an expensive and timeconsuming exercise; baseline surveys usually take several months to complete and twice as long to analyze. As a result, planners cannot wait for the information and it is left on the shelves to collect dust.

Many planners have sought ways to overcome these problems. One such method for collecting information about agricultural practices in rural areas in developing countries was developed in the 1970s. Known as *rapid appraisal* (RA), its purpose was to collect data quickly in order to deploy resources to those in greatest need. The original RA methodology focused on rural areas. However, the Urban Health Programme of the World Health Organization developed a draft RA methodology for data collection in urban poor areas. This draft was tested in an eight-day workshop at the Municipal Council, Mbeya, Tanzania, to plan interventions for improving the health situation. The results of this field testing, as well as other national experiences applicable to this methodology, were incorporated and printed by WHO in a document entitled, "Improving Urban Health: Guidelines for Rapid Appraisal to Assess Community Health Needs: A focus on health improvements for low-income urban areas."

The purpose of this paper is to introduce this methodology by briefly describing the eight-day workshop, the application of the methodology in other national experiences and to identify its strengths and weaknesses.

## Methodology

As indicated above, this RA method was developed during a workshop and tested in Mbeya, Tanzania. The introduction to the concept was the first step in undertaking rapid appraisal. It was explained that:

1. RA is a method to obtain important information rapidly: Only relevant and necessary information should be collected. It is not intended as a household or other type of extensive survey giving details of specific problems.
2. RA is based on three sources of information: *documents*, *key informants*, and *observations*.
3. RA is undertaken by professionals in multi-disciplinary teams so that various aspects of information about one subject can be explored and a range of experiences can be applied to judge the importance and validity of the information received.
4. RA is not merely a *method* for collecting data about the health problems of the urban poor, but more importantly, a process on which to formulate a plan of action to improve the living conditions of the people, based on their participation in defining their own problems.

The second step was to present a framework for data collection and analysis. The idea of using an "information pyramid" for obtaining information was introduced. Participants were informed that the blocks of information to build the pyramid were collected from the three sources identified above.

To reinforce the value of separate information sources, it was suggested that participants write information gathered from documents on yellow cards, from key informants on pink cards, and from observations on green cards. These cards would then be placed in the relevant category in the pyramid. This enabled participants not only to see where the information was gathered, but also the areas where there was too much information and where there was too little.

The next step was to explore the information pyramid in detail. Participants were divided into three teams composed of members from different sectors. Each team brainstormed on questions necessary to build the blocks of the pyramid. Using white cards, they wrote down each question, which was then read out, placed on the appropriate block of the pyramid (which had been drawn on large sheets of white paper and attached to a blank wall) and then grouped together around specific issues. These groupings provided the basis for categorization of data and they could also discern when there was either too much or too little information. After these issues had been identified, participants discussed from which sources information might best be obtained.

The types and kinds of observations were discussed and checklists were developed for information from interviews and documents based on the categories of the information previously described. Participants were then requested to examine key documents to glean data from this source. They were asked to give general information about Mbeya based on these documents. Key informants were identified, including government officials, party officials, social and health service personnel, teachers, community leaders (heads of community organizations, religious leaders, women's groups, informal leaders) and members of nongovernmental organizations working in the area.

## **Data collection and analysis**

The first field visit was conducted in three wards selected by the Municipal Medical Officer, with each team going to a different ward to meet with ward officials and present the reasons for the interviews.

Much time was given to key informant interviews. After the first round of interviews, participants returned to follow up some questions and to see other people who had not been identified during the first round. After these two visits, the entire group met and reported their answers, based on the interviews, to the following questions:

1. *What* were the major problems?
2. *Who* told you about these problems?
3. Did your *observations* confirm these problems?
4. Do the *documents* suggest that these are problems?

Scrutinizing the answers to these questions revealed a major problem: Participants had no way of assigning any priority to the problems. As a result, arrangements were made for a return visit to the key informants to ask them to rank in order of priority the problems they had identified. To do this, each key informant was given cards with identified problems and asked to put them in order of importance. Blank cards were provided in case a problem was identified that had not been recorded earlier.

## **The final workshop: Planning processes and plan of action**

Once the data had been analyzed and priorities for each ward identified, participants considered how to develop a plan of action to respond to the problems. Participants made a list of possible solutions to priority problems. A matrix was then introduced to rank the feasibility of each recommendation. Each group was asked to choose solutions for a problem in the ward it had surveyed and to judge its practicality by using the following criteria:

1. *Health benefit* (what is the potential overall health impact?)
2. *Community capacity* (how committed was the community to solving the problem and what could they contribute (money, manpower, materials) to its solution?)
3. *Sustainability* (could the intervention be maintained, and at what cost?)
4. *Equitability* (which income groups were to benefit most?)

5. *Cost* (what were the initial capital and manpower costs?)
6. *Time frame* (how long would it take before changes were noticeable?)

Each recommendation in these categories was given a score of "+" for low benefit, "++" for medium benefit, and "+++" for high benefit. The highest score was given the highest priority. Upon this basis, a plan of action was drawn up and the responsible people identified.

### **Application of the methodology in other national experiences**

This methodology has been used in other national situations for the same purpose of planning with the urban poor. In Dhaka, Bangladesh, a rapid appraisal was undertaken by a Government Urban Health Care Committee, sponsored by the Government of Bangladesh Directorate of Primary Health Care and the World Health Organization, to obtain information and community involvement for a pilot project for slum improvements. Using the WHO Guidelines developed from the Mbeya experience, an RA was done by a multi-disciplinary team, including members of the Government Health Services, which gave a profile of the problems. These results were presented in a two-day workshop attended by government, municipal and community representatives, as well as the investigating team. A number of problems requiring immediate action were identified. Support from both the community and the authorities was promised and persons were identified to take responsibility.

One apparent spin-off of this exercise was the recognition by the Regional Committee of WHO's South-East Asia Region of the importance of such an approach and a recommendation was made to undertake RAs for problem identification and solution.

This methodology has also been useful in the United Kingdom where a reorganization of the Regional Health Authorities is taking place. The South Sefton Health Authority, near Liverpool, gave priority to health improvements for one of the poorest areas in its domain and wanted to identify the more urgent problems. Although the Authority had much recorded data, it had no way of knowing how they reflected the needs and priorities of that specific community. The authority undertook an RA using the WHO Guidelines.

The value of this approach has been shared with other Regional Authorities in the United Kingdom and has generated a great deal of interest. The South Sefton people felt that a major strength was its flexibility in terms of time and approach.

### **Strengths and weaknesses of the methodology**

In the health field, RA is an unfamiliar approach to data collection. The experiences described above allowed the methodology to be tried and an assessment made of its strengths and weaknesses. The assessment is summarized as follows:

#### ***Strengths***

- RA provides a methodology whereby planners/managers of programmes are involved in the whole planning process from information collection to development of action plans. Equally important, it provides a basis for involving community leaders in the planning process.
- RA helps planners see how working in multi-disciplinary teams contributes to, and draws upon, experiences from other sectors. Participants felt that they had gained much by sharing their particular assessment of problems in poor urban areas and ideas for their solutions. They also valued the teamwork approach to interviewing as, by sharing the burden of asking questions and recording information, no one person had all the responsibility.
- RA helps planners discover aspects of community life unknown to them before the investigations. Participants working in institutions have been helped by this methodology to discover community problems and to enter into dialogue with community leaders. It often helped those familiar with community work to identify organizations, activities and/or work they did not know existed.
- RA helps planners to see the value of community involvement, particularly through semi-structured interview. These interviews had the advantage of allowing interviewees to expand their interpretation of problems, as well as to develop a dialogue with municipal officials/resource holders. As a result, participants felt that they had not only a better understanding of community problems, but also a basis for contact with community leaders to try to solve those problems.
- RA is a method by which priority for surveys can be identified, saving both time and money and allowing rapid development of plans of action.

### *Weaknesses*

- There is a need to overcome bias in the sample. There is no "objective" sampling technique. Key informants who give a narrow and biased view of the problems may be inadvertently selected. The planning teams need to be made aware of this and to spend adequate time in selecting informants so as to avoid this problem.
- Sufficient time to complete the planning process is needed. Data collection without the development of a plan of action is not useful for an RA that has the objective of both problem identification and planning with community involvement. Conducting the workshop over a period of months, as in the Liverpool experience, may be one way of overcoming this problem.
- There is a need to overcome interview problems. As many people have little experience in conducting interviews and making useful observations, some training is necessary. Role playing or pilot collection of information, with appropriate comments from facilitators, can help solve this.

## Conclusions

Except for application to the field of health, RA is neither a new method nor is it confined to specific situations addressing the problems of the poor. Based on the experiences described above, it would appear to have some definite advantages in attempting to establish a primary health care programme for the urban poor. One is that it involves community dialogue at the very early stages of programme planning to build a basis for negotiation and partnership between resource holders and beneficiaries. Another is that fairly quickly, easily and cheaply it provides data on which to base plans for improvements. A third is that it allows the planners/managers to handle the whole planning process from the beginning rather than have a separate group collecting the data on which programme decisions will be made. However, RA is only the first step in the planning process. It should not be used to provide detailed information about problems or be a single activity without a follow-up commitment to take action on the problems identified. Finally, the use and validity of this approach toward improving the health of the urban poor will not depend on undertaking it, but on the interest and commitment of the authorities to deal with the complex problems it identifies in the slum and squatter areas.