Improving Urban Health

Guidelines for rapid appraisal to assess community health needs

A focus on health improvements for low-income urban areas

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Guidelines for Rapid Appraisal

PREFACE

The need to develop a rapid and cost effective method to assess community health needs of low-income urban areas has become a pressing concern. This is mainly due to increasing recognition, both nationally and internationally, of the plight of populations in underserved urban and peri-urban communities, especially in developing countries. This situation has become serious due to urbanization and urban growth, and this trend is likely to continue. The forecast is that during 1990-2020 the populations of towns and cities in Africa and South-East Asia are likely to increase by 30-60%, and in Latin America 80-85% of the people will be living in urban areas. In order to facilitate the development and improvement of action plans, these Guidelines have been formulated to enable health managers to appraise the needs, jointly with the community, and to address the health problems of low-income urban populations. The Guidelines are focused on the principles of primary health care, equity, participation and multisectoral cooperation.

The Guidelines were prepared by Dr Hugh Annett, Senior Lecturer, and Dr Susan Rifkin, Honorary Senior Lecturer, both of the Department of International Community Health, Liverpool School of Tropical Medicine. Suggestions and comments made by various programmes in WHO headquarters were incorporated, for which we are grateful.

The Guidelines are the outcome of support provided by the Swedish International Development Authority (SIDA), the Swedish Agency for Research Cooperation with Developing Countries (SAREC) and WHO collaboration with countries within the Programme for Improving Urban Health.
The Guidelines drew on the experiences of an urban primary health care project initiated, with assistance from WHO, in Tanga, Tanzania by Dr H. Kasale, Medical Officer of Health, Tanga Municipal Authority. They were field tested in Mbeya, Tanzania, in collaboration with the Mbeya Municipal Authority and in Liverpool, where the South Sefton Health Authority used Rapid Appraisal to help restructure the work toward locality management.

The Guidelines have been amended as a result of this field testing. Their limitations are noted in the text. It should be realized that Rapid Appraisal is only a step in the planning process and limits itself to the perceived needs of the community and their participation. Concerning their potential, one of the overwhelming comments of the participants, city health and municipal teams in assessing the methodology has been the discovery of aspects of community life which were unknown to them before this investigation. In Mbeya, where Rapid Appraisal was undertaken, for some of the participants, and particularly for those who are based in a hospital or training institute, the discovery of the problems in poor communities was an important insight. For those who actually participated in community work, the discovery of organizations, activities and/or problems which they did not know existed was important. In Liverpool its use was recognized as a means to involve local people in planning and monitoring health interventions, as well as a means by which to develop and maintain intersectoral multidisciplinary planning. In addition to field testing, the Guidelines were used in a Training Workshop on Health Systems Reorientation in Urban Areas to Reach the Underserved held in Lusaka, Zambia in April 1989.
Guidelines for Rapid Appraisal

In the Training Workshop in Lusaka, participants stated that application of the Guidelines was a useful method and an extremely important tool for the identification of community needs and for the means by which a community could contribute to its own health development. It was considered a good way of analysing current health activities, especially for health professionals and planners in assessing the causes of ill-health in a community, its basic problems and their priorities.

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1. INTRODUCTION

1.1 BACKGROUND

How do we measure health improvements? In the past, because health improvements were presumed to be mainly a result of progress in biomedical technology and in-service delivery, health status was seen as a sufficient measure. However, with the recognition that good health is also the result of socioeconomic conditions and with the acceptance of Primary Health Care, other measures of achievement became necessary. These include whether health services and health care are accessible, acceptable and affordable. With PHC it is clear that quantitative measures alone do not define problems or prove progress. It is also necessary to assess the processes by which desired changes for better health occur.

WHO has begun to meet this challenge in developing methods for country reviews of PHC. These reviews, done by teams of WHO staff members and nationals, have analysed changes in national health systems by examining the impact of health services, as well as processes of community involvement and of the search for equity. Lessons learned from these experiences are now being integrated into the development of district health programmes.

In this document, the lessons of the PHC reviews are used as the basis to address another major concern of WHO - that of improving health for people living in low-income urban areas. In this context, the challenge to health planners and managers for replanning is to obtain better insight into the problems of the community than is available from routine information, to set priorities on ways to reduce the major threats to health and to
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develop a plan of action. As there is little time and money available to collect basic information to develop these plans, a method which provides rapid results, assessing both qualitative and quantitative aspects of health problems with minimum cost, is valuable.

One way of obtaining this information is to do a rapid appraisal in which health managers review the existing records, interview key informants and make observations, then, together as a team, and with community participation, try to work out community priorities for action.

As explained later in this document, rapid appraisal methodology is not new nor is it the only methodology possible to get information needed for planning. As a method to improve urban health, however, it not only benefits from a fairly quick and cost-effective approach, but it also strengthens the PHC principles of equity, participation and multisectoral cooperation. In terms of equity, it focuses on members of urban environments that are still denied the benefits, often legally and certainly in concrete terms, of the residents in more affluent urban situations. In terms of participation, it uses key informants (members of the community who, because of their official or unofficial leadership positions, represent a wide range of community views) to both identify community problems and to contribute to solutions. In terms of a multisectoral approach, it uses resources holders, such as municipal authorities (including health staff, sanitary and water engineers, architects, social workers and financial planners), to do the investigations and to make a plan of action to address priority problems.
The methodology presented here is only the first step in a process to formulate a plan of action. Further steps are briefly discussed in the last chapter and references made to documents where details may be found. This step, however, is perhaps the most crucial both for the information gathered and the mechanisms developed to obtain and act upon this information. By taking professionals with a range of expertise to address health problems, by involving community members in both the identification and solutions to these problems and by using the method as the means, not the end, of an action programme for health improvements, rapid appraisal makes an important contribution. It presents the opportunity to lay a strong foundation for the PHC approach to improving health in low-income areas.

1.2 THE URBAN SITUATION

The policy of Primary Health Care accepted by the Member States of the World Health Organization at Alma-Ata in 1978 was intended to address the problems of those to whom health care was not affordable, not accessible and, in its existing form, not acceptable. As the majority of these people lived in rural areas, the focus of efforts began here. It was shortly recognized, however, that the health problems which plagued the rural poor could be seen in the slum and squatter settlements in urban areas. These problems, particularly in the developing world, multiplied at a rate which kept pace with that of urban population growth and with demands on inadequate and poorly structured urban services. Primary health care for urban areas no longer waits for lessons from the rural areas. It commands immediate and prompt action.
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To justify concern for the health of urban populations, it is only necessary to review recent United Nations statistics. In 1920, 14% of the world's population lived in cities. In 1985, 41% were urban dwellers. By the year 2010, it is projected that more than 50% will be urban inhabitants.

Statistics on urbanization point to some important trends (WHO, 1988). Firstly, urbanization no longer affects only a minority of people; a majority now are touched by its influence. Secondly, urbanization is not only a problem for the industrialized world, but is also a major demographic feature of the developing world. Thirdly, rapid urbanization is no longer confined only to capital cities. Fourthly, urbanization is not a temporary problem. Only 40% of the increase in population growth on the average is due to migration; the remainder is due to natural increase. Finally, and probably most important, urbanization means that in many countries, especially in the developing world, 50% of urban residents live below the poverty line. The problems of urbanization are often synonymous with the problems of the poor and their impact and influence on the cities of the future.

The health situation which arises from this rapid urbanization mirrors the problems of poverty. Poor physical health reflects such factors as lack of income, lack of food for proper nutrition, lack of a clean environment, lack of space and lack of access to health and social welfare services. These conditions result in illnesses of stress due to lack of security of land tenure and income; in communicable diseases due to congestion, poor sanitation and little clean water; and
injuries due to pollution, accidents and violence. They are complicated by the absence, in many areas, of strong community roots. As a result, concerted community action to improve these conditions is often difficult.

The World Health Organization and UNICEF, the conveners of the Alma-Ata Conference, during the past few years have held a number of meetings to identify approaches which can improve the lot of low-income urban populations (WHO, in press). These approaches, based on the primary health care principles of equity and social justice, highlight the need for the participation of communities in solutions to their own health problems; for collaboration among the various government sectors concerned with providing services for the urban poor; for reorientation of those involved in giving health services; for new ways of planning for urban areas; and for more research into defining the problems of low-income groups in urban areas. It is this latter concern which is being recognized as the most crucial, for the others depend on an accurate definition and understanding of these problems.

One of the greatest difficulties in defining the problems of low-income urban areas is lack of data. While aggregate statistics are available to show differences between health and health care in urban and rural areas in countries, there is little information which indicates inter-urban differentials. What information is available is often inaccurate. The reasons for this situation are varied, but they do include the mobility of urban groups, the suspicion of local residents about outside people asking questions and the lack of community organizations.
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The result is that data collection is often seen to be expensive and time-consuming, and, in the end, of questionable value. It suggests that a rapid and easy method for collecting information to accurately identify health and health-related problems is needed to plan health improvements for the urban poor.

1.3 PURPOSE OF THE DOCUMENT

This document introduces the concept and a methodology of rapid appraisal for those who are responsible for seeking solutions to health problems of low-income people in urban areas.

The purpose of this document is:

- to enable health managers to collect data to build information pyramids for developing a plan of action based on community needs;
- to enable health managers to get this information through a rapid appraisal of health problems arising from the inadequacy of the existing health care system and the impact of the urban environment on the individual and the community, particularly in low-income areas, by assessing:
  (a) community needs, structures capacities and involvement;
  (b) the physical and socioeconomic environment;
  (c) the availability of health, environmental and social services;
  (d) government and municipal health policy.
2. INFORMATION PYRAMIDS FOR URBAN HEALTH PROGRAMMES

2.1 BUILDING AN INFORMATION PYRAMID

This document presents a set of guidelines by which to undertake rapid appraisal for urban areas. For this reason, this document is both a checklist of information needed and, equally important, an approach for obtaining data which will enable planners to have imperfect, but useful, information by which to identify urban problems and seek action for solutions. It advocates the primary health care approach which rests on the principles of equity and participation. The guidelines use information pyramids for low-income urban groups in order to develop relevant action plans for health improvements. An information pyramid is a description of the health situation of people living in a defined geographic area, which enables planners to identify potential interventions to improve the situation, particularly among the most deprived. These pyramids have three characteristics:

- they are based on needs identified by the community;
- they are built on information gathered from documents, from a dialogue between planners and community members and from observations of planners in the community;
- they are constructed with the recognition that urban communities often experience comparatively rapid change and, therefore, the pyramids only reflect the situation at a given point in time. In other words, the pyramids change, as information is gathered at various points in time.
Guidelines for Rapid Appraisal

FIGURE 1. BLOCKS FOR AN INFORMATION PYRAMID

The foundation is built on information about community composition, organization and capacities to act. Because the planning process is based on community involvement and contribution to a plan of action for health improvements, health managers will need to know about the community with whom they are working. It will be necessary to find out the strengths and weaknesses of the community leadership, organizations and structures.

The next level is that which describes the socio-ecological factors which influence health, including the physical environment, socioeconomic conditions and disease and disability. Information here is necessary in order to investigate the potentials and barriers which exist for community improvements. Data on the physical environment seeks to identify the environmental causes of disease and disability,
problems such as overcrowding and pollution. Data on the social aspects focuses on traditional beliefs and values which facilitate or impede behavioural changes. An analysis of economic aspects highlights income sources, earning potential and the economic opportunities of various community groups.

The third level concerns getting data on the existence, coverage, accessibility and acceptability of services. These include health services, environmental services such as water and waste disposal and social services such as education and assistance for the disabled.

The final level on which some general knowledge is required is that concerning national, regional and local policies about health improvements for low-income areas. Information on these policies, particularly health policies, will tell whether the political leadership is committed to primary health care. With strong government support at both the top and local levels, urban health improvements for low-income areas will have the sanctions to proceed more rapidly and without major political barriers.

Information pyramids are built from data gained by rapid appraisals. When planners do a rapid appraisal to plan for health improvements, they will collect blocks of information about these four general levels to build the pyramid. The pyramid shape reminds health managers that success depends on building a planning process which rests on a strong community information base and that the amount of information needed about each area is relative to its position on the pyramid. It is the quality of the information, not the quantity, which is most crucial.
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3. RAPID APPRAISAL FOR URBAN ASSESSMENT

3.1 WHAT IS RAPID APPRAISAL?

Rapid appraisal is a method of getting information about a set of problems in a short period and without a large expenditure of professional time and finance. For our purpose, rapid appraisal is the first step in the process of planning health interventions for specific communities.

Rapid Appraisal is the beginning of a process for collection information to make a plan of action. Rapid Appraisal is not a method for collecting extensive data on one geographical area or one particular health problem.

The term "rapid" refers both to the time spent in the field collecting the data and the time spent analysing the data. This should be the minimum acceptable time to gather information by which to develop a plan of action. Rapid appraisals have been seen by many to be similar to an exercise in mapping a particular geographic area. They help to describe the main features such as the hills, rivers and valleys, but they do not tell how high the hills are, or how deep are the rivers and valleys.

Rapid Appraisal tells WHAT the problems are, NOT HOW MANY people are affected by the problems.
Rapid appraisal is also a method of needs-based community assessments. As a tool for participatory planning its goal is to involve those who are the less advantaged in urban areas in identifying their own needs and, together with the health managers who have resources to meet those needs (municipal authorities and nongovernmental organizations), in planning to act upon problems.

Rapid appraisal gained popularity among rural development planners in the late 1970s as a method by which to quickly deploy resources to alleviate the problems of the rural poor. It was commonly used to assess rural development potential. The approach was not without problems, which included investigator biases, unawareness of the effects of seasonality and problems of unrepresentative sampling (Chambers, 1983). Yet, experience has shown that, if carefully planned and used with common sense, rapid appraisal can provide a basis on which action can be taken (Khon Kaen University, 1987).

Rapid appraisal rests on three principles (Facey, 1980; Chambers, 1983; Scrimshaw & Hurtado, 1988). The first is to collect only relevant and necessary data because this is the only way in which a rapid assessment can be made. The data should not be collected because it is readily available, or it might eventually be used. The data which is collected should be minimal and relevant. It is self-defeating if the data is quickly collected and then demands twice the time to analyse.
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The second principle is to identify the information which is needed and find acceptable ways of gaining that information. While information may be directly abstracted from written documents, other ways must be found to gain information from people. Often, the information cannot be extracted by asking a direct question, and the answer must rest on a substitute question or observation as a "proxy" for a direct question. The most striking example of this use of proxy information is that of assessing family income. This is particularly true in low-income areas where there is high unemployment, wages are non-existent and, therefore, are not useful to assess family income. A proxy question such as: what is the household expenditure? or what type of material is used to build the accommodation? or what kinds and numbers of meals do family members have? might have to be used as an indicator of family income.

The third principle is to involve the community in the rapid appraisal exercise. From experiences of those working in urban low-income areas, this principle has a further extension. It is the necessity of involving the community in defining their own problems and seeking relevant solutions, not merely feeding back information for planners to use to gain acceptance of a predetermined health intervention (Harpham et al., 1988). Where programmes, albeit mostly only small scale, have worked, it has been where the people and decision-makers planned together steps for community health improvements. Banerji (1986) discusses in detail how this approach allowed Indian planners to gain acceptance of their programmes for tuberculosis. Others have described how needs-based planning has led to relatively cost-
effective, self-sustaining programmes (Harpham et al., 1988; WHO, in press). Among poverty-stricken people where resources are scarce, land security and income are tenuous and overcrowding is a main cause of illness, interventions which do not gain the support of those who can benefit are likely to be at best misused, at worst ignored.

**PRINCIPLES OF RAPID APPRAISAL**

1. Do not collect too much or irrelevant data.
2. Adjust investigations to reflect local conditions and specific situations.
3. Involve community people in both defining community needs and identifying possible solutions.

The data from rapid appraisal methods is collected from three main sources:

(1) existing written records;
(2) interviews with a range of informants; and
(3) observations.

With the data collected by these means, it is possible to build a pyramid, though somewhat superficial, to describe a specific community and to begin to identify problems and priorities.
Guidelines for Rapid Appraisal

To be effective, rapid appraisal depends on investigators having important attitudes and skills (Facey, 1980). The first is the determination to find and follow and then examine critically the existing written record. The second is the willingness to learn from local people and use indigenous resources. The third is to be able to listen carefully both during interviews and informal conversations. The fourth is to keep a sharp eye open and to observe the surroundings for clues about problems and potentials. To these four, we might add a fifth: it is to use common sense in analysing the information. If the conclusions do not reflect the managers' professional knowledge and experience, then it is probably necessary to review the interpretation of the data.

**ATTITUDES AND SKILLS NECESSARY FOR RAPID APPRAISAL**

1. Determination for discovering and examining written records.
2. Willingness to learn from local people and use indigenous resources.
3. Careful listening during both interviews and informal conversations.
4. Awareness and sensitivity to everything that can be directly observed.
5. Use of common sense in analysing the information.
3.2 HOW CAN RAPID APPRAISAL BE PREPARED?

Rapid appraisal is a team exercise. It is also an exercise carried out in the field. The team consists of people who have a wide range of professional skills and expertise. In the urban setting, health problems of low-income groups need to be solved by health staff, sanitary engineers, architects, social workers and municipal financial officers among others. These people representing their professions, as well as the municipal authorities, should be members of the team undertaking the assessment.

Rapid appraisal for identifying health problems in low-income urban areas is best done by a multisectoral team.

Rapid appraisal can be carried out quickly and without a great deal of time and cost, by bringing together the people responsible for planning and managing urban health improvements for a 10-day workshop: in this period it is possible to complete a rapid appraisal exercise. The workshop should be facilitated by at least one person who has had experience in rapid appraisal. His/her role is to serve as a focal point for decisions and facilitate the discussions.

The workshop is introduced by explaining the purpose and methodology of rapid appraisal as a first step of a planning process for developing a plan of action for health improvements. This step focuses on building the information pyramid discussed in Section 2.1. The participants then
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Identify the essential data needed to build the information pyramid for the community with which they are concerned (see Section 4.2). The information-gathering instruments are prepared and the likely sources of data (from documents, from interviews and from observation) identified.

The collection and analysis of the required data, done mainly in the field, occupies the workshop participants for five or six days. The concluding sessions of the workshop should focus on what steps will be taken to draw up and implement a plan of action. The workshop might follow the timetable given in Appendix I.

For some municipalities, however, it may be impractical to set aside a 10-day period for the conduct of the rapid appraisal. When this is the case, it is possible to hold an introductory three-day workshop, and have the data collection fitted into the normal working schedule of the investigators over the next two to three weeks. Once data collection is complete, a concluding workshop of two days will be necessary to complete the analysis of the data and prepare a plan of action. This approach to rapid appraisal is more difficult to manage and may yield less useful results than a rapid appraisal conducted through an intensive 10-day workshop. But it can still be a very useful exercise. A possible timetable for this second option for conducting rapid appraisal is given in Appendix II.

Rapid appraisal can be done by following a series of steps. These are:
Steps for Rapid Appraisal

1. Decide what information is needed.
2. Decide how to get information:
   - documents;
   - key informant interviews;
   - observations.
3. Collect information.
4. Analyse information:
   - data and professional "common sense";
5. Review findings with key informants.
6. Define priorities.
7. Make a plan of action.
8. Monitor and evaluate.

3.3 UNDERSTANDING THE LIMITATIONS

For rapid appraisal to be used for planning to improve health among the urban poor, it is important to understand its limitations. As has been emphasized previously, rapid appraisal is a critical step in the planning process for a plan of action based on community perceived needs. It is not:

- a detailed household survey which quantifies the size of the problem. After problems have been identified and given priorities by planners, together with key informants, a detailed survey may be necessary (see Section 5.2). However, this is not the same as a rapid appraisal;
Guidelines for Rapid Appraisal

- a collection of interviews based on grassroots informants. The informants in rapid appraisals are chosen because they are in a position in the community to represent views of a group, or groups, of people. Further collection of individual community opinions would not only complicate the analysis, but also would add time to the process;

- a basis for comparison of problems in different areas in the same municipality, or in other municipalities. Rapid appraisal is specific to the situation for which planning for health improvements is to be undertaken. Because it is a step in the planning process for a particular group of people, it cannot be seen as an isolated collection of data outside the planning context. It might, however, highlight common problems and be a guideline for actions in other communities or in other low-income groups in other cities.
4. GUIDELINES FOR DATA COLLECTION AND ANALYSIS

4.1 DEVELOPING A TIMETABLE

The guidelines in this document are developed on the basis that the entire rapid appraisal can be completed either within two weeks by a team of about 9-12 people giving complete concentration to the rapid appraisal, or within about one month by a similar team giving part of their time to the rapid appraisal as proposed in Section 3.2. It suggests that for data collection and analysis for rapid appraisal, a team of three to four people interview between 15 and 20 persons and do some individual follow-up interviews. Should there be a desire to interview more people, or should there be a decision to reduce either team members or interviewees, adjustments need to be made accordingly.

In preparation for data collection, sources of written records should be identified; decisions should be made about who is to be interviewed, how many times, where and when. Tasks should be assigned to team members and agreement reached upon the time these tasks should take. A time schedule for collecting and analyzing information, with responsibilities assigned to each team member, can now be produced.

Case Study

An appraisal team of 10 people, consisting of officers of the municipal council and an active nongovernmental organization in the city, decided to do a rapid appraisal to target plans for improvements for the urban poor. After testing their questionnaire and identifying key informants, they divided the work among them. The municipal medical
Officer was assigned members of the municipal council to interview. The municipal health inspector was to interview key informants from the city's public health staff. Other team members did interviews at ward (the urban administrative district) level. They interviewed the ward officials, members of community organizations, including women's organizations, head teachers, religious leaders and "informal leaders" (old, respected men, owners of local shops). The interviews were to be completed within one month after which they were analysed and a second interviewing round was undertaken. A report was presented at a workshop of municipal officers and representatives from the provincial and national health ministry.

4.2 OBTAINING DATA

Methods of data collection for rapid appraisal include reviewing of relevant documents, interviewing key informants and making observations about community problems. Section 2 provides a framework for data collection and analysis.

In Appendix III, areas about which information may be collected are identified and the importance of this information is discussed. Obviously, it is not possible to collect information about each of these areas. However, this Appendix may be useful in some of the following ways:

- it can serve as a basis to develop an interview protocol and to identify data to be extracted from written records;
- it can remind planners about areas on which information might be usefully recorded as observations;
- it can aid in interpreting information.

In addition, obviously, the areas for which specific information is needed depends on the local situation. This Appendix is provided in order to give a general direction for inquiries about problems among low-income urban communities.

The decision about what information is to be obtained and how this information is to be collected must rest with the planning team. One reason is that each city will have a different amount of information already available: areas for information-gathering must be identified on this basis. Another is that the exact questions which need to be asked will depend on local situations. A universal checklist is not possible to develop. Finally, as has been stressed, rapid appraisal is part of the planning process. The identification of the information needed to create a plan of action and the development of how this information is to be collected, is a crucial part of this process.

4.2.1 Questions to be Asked

To collect information, questions about specific areas identified in the information pyramid need to be asked. These questions, reflecting the local situation, are developed during the workshop. The questions should seek only information which is relevant. If the answer cannot contribute to building the information pyramid, then it should not be asked. Although there is a risk that data which would be useful, but has not been identified in advance, is not collected, it can be
Guidelines for Rapid Appraisal

minimized by remaining flexible: you can ask questions about subjects which are recognized as important at the time of interview.

Only ask questions for which the answer will provide information that you need.

Once the questions which need to be asked to complete each block of the information pyramid have been agreed, they are used by the team at the workshop to prepare a checklist of information for the semi-structured interviews.

Case Study

In a 10-day workshop where city officials undertook a rapid appraisal for developing action plans for three squatter areas, the information pyramid was explored in detail on the morning of Day 2. Participants were divided into three teams composed of members from different sectors. (They remained in these teams throughout the data collection and analysis.) Each team was asked to brainstorm on questions which they needed to build the blocks of the pyramid. Using white cards, they wrote the questions down. Each question was read, placed in the appropriate block of the pyramid (which had been drawn on large sheets of white butcher paper and attached to a blank wall), then grouped together with similar questions around specific issues. These groupings provided the basis for categorizing data. Based on these categories in the information pyramid, a checklist of information for
interviews and observations was developed. The checklist reflected a choice of information based on discussions about each item.

To plan the data collection it is useful to consider in advance where answers may primarily be found. The following table provides an example.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Documents</th>
<th>Interviews</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of water supplies</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Comparative income of people</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Attendance at health clinics</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

However, in rapid appraisal it is important not to rely on a single source of information. It is necessary to cross-check data from one source with that from at least one other; it is preferable to have confirmatory evidence from all three sources.

Based on these decisions about the questions and the sources of data it is now possible to identify:

- documents to be reviewed;
- the names of key informants;
- areas in which observations should be made.

4.2.2 Data Sources

4.2.2.1 Reports and Other Documents

Although it is recognized that written records do have limitations, they are still an important source of information.
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They also provide a start for building an information pyramid. Records which might prove useful are listed in the box below. However, it is quite likely that others are available and known to the planning team. The team must continually remember that the purpose of rapid appraisal is to get relevant information quickly. Many of the documents relating to the rapid appraisal may be substantial, but contain a limited amount of relevant information; to attempt to read the whole of each document would be counterproductive. Thus, in reviewing written records, it is necessary to be highly selective about the information abstracted: the documents should be purposefully scanned rather than read in detail. As part of this step, discussions about what information is relevant are critical.

<table>
<thead>
<tr>
<th>SOURCES OF WRITTEN RECORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census statistics.</td>
</tr>
<tr>
<td>Municipal planning records.</td>
</tr>
<tr>
<td>Budgetary expenditures.</td>
</tr>
<tr>
<td>Surveys which have already been undertaken.</td>
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<tr>
<td>Studies undertaken at local universities.</td>
</tr>
<tr>
<td>Historical records.</td>
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<tr>
<td>Hospital and clinic records.</td>
</tr>
<tr>
<td>Studies undertaken by international agencies.</td>
</tr>
<tr>
<td>Surveys undertaken by nongovernmental organizations.</td>
</tr>
<tr>
<td>Ministry records, i.e. health, housing, environmental sanitation, water, social services, city plans.</td>
</tr>
</tbody>
</table>

In using records the following hints may be helpful:
(a) Reports of surveys by previous investigators may be valuable. A few well-organized communities may have prepared reports on issues of major importance. Agencies working in the settlements may have prepared reports for donors, the government or for internal purposes. It is likely that estimates of the infant mortality rate, and perhaps other indicators, will have been made for the municipality. However, these rates must be interpreted with great caution. Because cities are heterogeneous, aggregated data, in which the city as a whole is likely to compare favourably with rural areas, can hide the conditions of the inhabitants in low-income areas of the city. Where systematic stratification of city information has been undertaken, and disaggregated indicators are available, they provide useful summary information on the health of the population.

(b) While records may be poorly maintained there is likely to be some documentation, such as annual reports, available from the health centres and projects in a community. These should be reviewed with due regard for their likely inaccuracies. There may be official municipal or Ministry of Health reports which refer to the provision of services in the communities being assessed.

(c) Legal documents are often difficult to read for those who are not lawyers, while policy documents and health plans are less difficult. The former may be clarified by legal departments within municipal authorities. Institutes of Social Policy or Administration may have undertaken reviews of legislation in the light of new policies; these may be helpful.
Guidelines for Rapid Appraisal

(d) Once relevant data has been identified by scanning the document, it should immediately be recorded in as much detail as is required. The title of the document and other identification details (source, date, author) should be noted with the extract.

Case Study

A municipality decided to undertake a programme to improve the health of its urban poor. In trying to identify the scope and nature of the problems of the low-income people, it used rapid appraisal to assess community problems. It was necessary to find out where geographically most people lived, or where overcrowding was likely to be found. Fortunately a town plan had been commissioned by the municipality three years earlier. This record provided good sources of information about population density, location of municipal services and types of accommodation. Using this data, the team decided where they should concentrate their efforts.

4.2.2.2 Key Informants

One of the major sources of information is key informants. Key informants are people in the community who, because of official position or informal leadership, have access to information about community rather than individual problems. For this reason, they can be seen as representative of a range of opinions which the community holds.
WHO ARE KEY INFORMANTS

2. Social and health service personnel.
3. Traditional healers.
4. Teachers.
5. Community leaders:
   (a) elected officials;
   (b) heads of community organizations;
   (c) religious leaders;
   (d) women's group leaders;
   (e) informal leaders.
6. Owners of local shops and entertainment establishments.
7. Members of nongovernmental organizations working in the area.

REMEMBER: THIS MAY BE MODIFIED DEPENDING ON EACH SPECIFIC SITUATION

Government officials

The national government and municipal authorities are important sources of information on major municipal issues and on policy options which deal with these issues. They will also have information on specific communities marked for special attention. While some municipal officers may be members of the investigation team, those whose departments are not represented can be interviewed. Gaining the information and experience of government officials is crucial in the planning stages because these people will have to be involved in programme development.
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Social and health service personnel

The staff in charge of government/municipal and nongovernmental organization facilities and community projects will not only be sources of data on their own services, but on the activities of other service providers - traditional and private - in the vicinity. Staff actually working in and with the community will be the prime source of data. Supervisor or managerial staff, once removed from the field, however, will be sources of data on community-wide problems and on inter-community comparison. Those involved in enforcing legislation, social workers and health inspectors, can provide data on the benefits, or lack of benefits, under the law as well as information about the inadequacies of legislation. Other groups of service personnel who can provide information are private medical practitioners. A sympathetic private practitioner will be a good source of data on the services provided, clients served, standards maintained and fees charged in the private health care facilities.

Traditional healers

A knowledgeable traditional practitioner is an invaluable source of data on the numbers of traditional practitioners in a community, level of community use and the rates of their remuneration.

Teachers

Teachers, as a particular category of social sector personnel, are important informants because of their intimate contact with both children and parents of the community. If
children travel outside the community to schools, then the teachers responsible for these children should be interviewed. In many low-income areas, official educational facilities are simply not available. In these situations, volunteers who run informal schooling or crèches can often be useful sources of information.

Community leaders

Community leaders and representatives will be sources of data on a wide range of subjects. Those who are in official positions can provide an overall view about the community and its problems. They can also help to identify others who can provide more specific information. Formal leaders, however, often present views which do not necessarily represent all their constituents. (Politically, they may tend to favour those to whom they owe their position, often the economically advantaged members of the community.) Therefore, it is important to interview others, particularly representatives of vulnerable sections of the community, in order to see the concerns and needs of these groups: for example, women, and those who are the poorest of the poor. It could be misleading to rely solely on what formal community leaders, usually men, say about these sections of the community: the voices of the most vulnerable groups need to be heard directly.

Other informants on community matters are officials of organizations which operate in the community, leaders of religious groups and the heads of women's organizations. These leaders provide insights into the specific groups which they represent, as well as the problems of these groups within the
Guidelines for Rapid Appraisal

community as a whole. Also, informal leaders who have been identified during the interviews of influential people are often very good sources of information.

Owners of local shops and entertainment establishments

This category of informants are important because they are in contact with a broad range of inhabitants in the area. They hear of and see problems which may not, for various reasons, come to the ears of the formal leadership, escaping recognition by those in more specialized services. Although the information these people provide might be more difficult to analyse, it might also be very valuable as a means to identify problems overlooked by other groups.

Members of nongovernmental organizations working in the area

Although people attached to these organizations are usually not community residents, their work in the community gives them a knowledge and concern very valuable for assessing community problems and needs. While recognizing that some organizations with a narrow focus, such as tuberculosis control, will have a limited vision, others, particularly those concerned with community development, can provide an overview of the community rarely found from other key informants. They may also prove willing allies in the planning process, providing manpower and resources to undertake community improvement programmes.

Getting information from key informants can be done in a number of ways. Focus-group discussion is one method. A number of key informants are brought together to discuss their views with members of the management/investigation team. In using
this approach, team members need to be aware that peer group pressure can influence the views community members present.

Another method is the modified Delphi technique which has been applied in the health field by manpower planners (A. Levine, 1984; R. Gala Morere et al., 1980). This technique uses professionals to interview key informants and a second round of interviews to present results and check the analysis. Because of the positive experience of this technique in urban municipal planning for low-income groups, it is described in some detail in Appendix IV.

4.2.2.3 Observation

An important part of collecting data is observing the environment in which interviews take place. The person interviewing has professional skills to assess the problems not specifically discussed with the key informants.

Several types of observations can be made. The first is to examine the physical environment of the area. Problems of sanitation, waste disposal, lack of proper roads and poor housing can all be seen during visits for the interviews. These observations should be recorded and checked against the information which is given by the key informants.

A second type of observation is to look at the kinds of services provided: health, housing, education, to see how well these services are managed. Are the records well kept? Is the staff readily available and enthusiastic, is good supervision being undertaken? Professional experience will be particularly useful in making these observations.
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Interviewers might observe whether activities are being carried out to implement legislation regarding services and improvements in the area. Are the benefits to which low-income people are entitled available? Do people accept these benefits? Are the health services promised by primary health care policies available? Are they used?

Finally, observations might be made about the attitudes of the key informants during the discussions. Are certain people attempting to manipulate the interview to put across their own view which may not be representative of wider community views? Do interviewees have "hidden agendas" which they are pursuing in the discussions?

These observations should be recorded and compared with other team members during the data analysis. The experience of the team can provide a weighting to these observations which will determine how they might be included in the final report. Observations are important. They may verify or nullify information given verbally and point to areas which may have been overlooked, either intentionally or unintentionally, by key informants. An important observation should be discussed with key informants during the second round of interviews.

4.3 CONDUCTING SEMI-STRUCTURED INTERVIEWS

While written records provide the quantitative data concerning the urban situation, for planning purposes qualitative data is as critical. The former often does not define the differences between the urban rich and the urban poor, and certainly does not highlight in any depth the problems of specific groups. Semi-structured interviews with key informants
are the basis for making a plan, which rests on felt community needs and involvement of community people in solutions to these problems.

A semi-structured interview is a guided discussion and is conducted in a sufficiently informal manner that the informant can introduce subjects, or aspects of subjects, not anticipated by the interviewer. This type of interview is most appropriate for a rapid urban appraisal, as the subjects about which data is being sought are complex, requiring qualitative rather than quantitative answers.

It is difficult at the outset of a semi-structured interview to know how long a particular interview is going to take. Sufficient time should be allowed for establishing rapport and asking all the relevant questions in a relaxed, but efficient manner. Probably the interview will last no longer than an hour and, more likely, 20 minutes to half an hour.

4.3.1 Hints for Asking Questions

(a) In a semi-structured interview, a checklist of general questions, based on the areas identified in the information pyramids, should be prepared in advance. It is not necessary to prepare separate questions for each category of key informant. The advantages of using the same general questions for all interviews are saving time in preparation and, of more importance, obtaining responses from different sources on the same subject.

(b) Most questions will need to be open-ended, that is questions which encourage the respondent to answer in a free-ranging style.
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(c) Each question should be about a single idea, should use simple and unambiguous words and should be as short as possible. If the initial question is misunderstood it can be clarified for the informant.

(d) "Why" questions should be used sparingly. If used frequently they tend to put the informant on the defensive and stop the flow of information.

(e) Questions which influence the reply should be avoided (e.g., Don't you think that the community nurses should do more home visiting?).

(f) Questions using negatives (e.g., Is it not true that ...), thus inviting positive replies, should also be avoided.

Cultural constraints must be borne in mind in writing questions and acceptable ways found of raising subjects which are not usually discussed in an open manner.

4.3.2 Hints for doing Interviews

(a) In order for semi-structured interviewing to be productive, interviewers need a number of skills. The most important is to be able to put the informant at his/her ease and gain his/her confidence. Essentially, this is achieved if the interviewer is genuinely interested in the task and concerned about learning from the informant. Of equal importance is the practice of customary good manners in greeting, introducing oneself and telling the informant the purpose of the interview. This
Interview may be the first contact of an ongoing relationship, hence the interview must also be concluded in a friendly and polite atmosphere. (This, of course, is common courtesy.)

(b) In an introduction to the interview, there should be an explanation of why the interview is being requested and on whose authority. There should also be an undertaking, which must be strictly kept, that the completed information will be treated confidentially and that verbatim statements quoted in the final report will not be ascribed to any named individual. Including these points at the beginning of the interview is likely to be most convenient.

(c) The interview should include identification data on the key informant. This may include name, sex, age, role/position in the community, municipal authority, etc. It should also include the date, time and duration of the interview and the name of the interviewer. If this is not done there is a very good chance that confusion will result.

(d) The interview should start with the least controversial questions, in order to put the informants at their ease and create confidence.

(e) Once a line of questioning has been started, the interview should be constructed in such a way that the interview proceeds in a systematic manner.

(f) The interviewer must engage in active listening: he/she should check with the informant that he/she has correctly understood important points which the informant has made. He/she should ask the informant to clarify or give more detail on important comments, so that the informant may be more specific.
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throughout the interview. The interviewer should show that he/she appreciates the informant by the manner in which he/she sits or stands, and by thanking the informant from time to time for answers given.

4.3.4 Hints for Recording Data

It is not necessary to print special forms for the checklist or for recording responses and observations; a notebook can be used for these purposes. On the front cover of the notebook reminders for the conduct of interviews is recorded, for example:

- introduce yourself/your group: who you are; why you are here;
- ask if the person is prepared to be interviewed;
- ask if the person is happy for notes to be made on answers;
- record identification data: name, address, sex, age (guess), position.

The checklist is then written on the first page. In practice, observation and interviewing will most often be undertaken together – the one checklist serves as an aide memoire for both purposes. However, in recording observations with the responses of key informants, they should be clearly distinguished for easy analysis. This can be achieved by dividing the pages of the notebook into two columns, one for recording responses and the other for observations.
During the interview key points should be noted down in the appropriate column of the notebook. No attempt should be made to record everything that is said. The notes can be expanded, if necessary, after the interview, while the content of the interview is still fresh in the mind of the interviewer. If verbatim statements are being recorded, they must, of course, be written down in full during the interview. It is also better to make a note of observations when they are made. This note can also be expanded later if necessary.

These interviewing skills require practice and, for those whose normal working requires different interpersonal skills, a conscious effort must be made to acquire and use these skills.

4.3.5 Field Testing

It is often the case that questions which are very clear to the interviewer are vague and/or misunderstood by the interviewees. Thus, once the areas of needed information have been defined, the team could profit by spending half a day doing a pilot study among groups of people similar to those who will eventually be interviewed. Such an exercise enables questions to be identified which are unclear, or which get a response different to that which was anticipated, or which are difficult for the respondent to understand or answer.

Field testing has additional advantages. It allows the team to discover how long it will take each key informant to answer the questions. It also allows the team to see how the work might be divided and which team member might be responsible for what task. Team members will also have an opportunity to test their skills for conducting semi-structured interviews.
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They can help each other become aware of how well each is willing to learn from local people, listen to formal answers and informal conversation and observe their surroundings.

Case Study

Once the planning team in a municipality developed their questions, they field tested them in three different urban low-income settlements. An original question had attempted to assess income in order to identify the poorer members of the community. When they first asked community leaders how many people were very poor, the respondent always gave a person’s name. Key informants could not conceptually find a criterion for identifying the poorest. As a result, the attempt to find out the very poor by assessing income had to be abandoned. The team had to rely on the city planning report, which indicated the most congested areas, and on observation of the most overcrowded areas.

4.4 ANALYSING THE DATA

4.4.1 Introduction

Most of the data collected in the interviews, by observation and from documents will be qualitative: statements, opinions, descriptions – none of which are readily quantified. The processing of qualitative data is more difficult than that for quantitative data. It is therefore all the more important to approach it in a systematic fashion. The procedure can be divided into three phases:
identifying categories;
- sorting answers;
- interpreting findings.

Once again the information pyramid can be used as an aid in this process.

4.4.2 Identifying Categories

To make sense of the data collected it is necessary to group the different answers and observations for each question.

Case Study

In a workshop for rapid appraisal the information pyramid was used to identify specific areas about which questions should be asked. The specific areas for each block of the pyramid about which information was collected, formed the categories into which the data from documents, responses from key informants and observations were grouped. Information collected from documents was written on yellow cards, from key informants on pink cards and from observations on green cards. The cards were then placed in the categories of blocks of the information pyramid. Using this approach, data collection and analysis proceeded simultaneously.

4.4.3 Identifying Community Problems

The first step is to compare the information from key informant interviews with information obtained from the review of secondary documents and from observations. If there are large discrepancies in the sets of data, the areas of difference
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should be noted and a decision taken about how to validate the findings. At this point the team might decide to undertake a more intensive survey to confirm one set of findings (see Section 5.2).

The second step is to summarize the data of each category to produce a concise statement of the main findings for each question. These summaries should be reviewed and discussed by the whole team. Once confirmed in this way, the summaries of the findings of the rapid appraisal can be grouped into the blocks of the information pyramid for the community (see Section 2). The pyramid then forms the information base for the final report of the interview team.

The third step is to identify the major problems. The team uses the findings, observations and professional knowledge of the team members to make a list of the major problems in the community surveyed. This list may well include problems which the professionals identified but community members did not. Whether these problems are important to community people is validated in the next step.

The final step is to return to the key informants to ask their opinion on the priority which they place upon the different problems identified from the data analysis. One way in which this can be done is to write each problem on a card and ask each key informant to order the cards in the priority which they attach to the problem. If a problem has been identified by the team which is not seen as a problem by community leaders, it will be given low priority in the final priority setting exercises. This was the method adopted in the following example.
Case Study

After a rapid appraisal team had analysed the data they had collected and identified problems for the squatter areas where they were conducting their investigation, they arranged 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 eight cards with the name of one identified problem on each card, then asked to rank these cards according to the most important problems. Once all the key informants had ranked the problems, each informant's ranking was scored by giving a score of eight to the problem given the top priority, a score of seven to the second priority, etc., so that every rank received a score proportional to its position. For each problem, the average score of all the key informants was then calculated, to give an overall list of priorities based on the opinion of all the key informants.

4.4.4 Developing a Priority Matrix

Once the data has been collected and analysed, the team is ready to seek solutions to the identified problems. During the interview, key informants, no doubt, will have raised some ideas about how to tackle the problems which they have identified. In addition, various team members also will have ideas about what their departments might have in terms of resources. The team must now decide which interventions they are prepared to undertake.
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Practitioners of rapid appraisal in the rural sector have suggested that this step might be done by developing a feasibility matrix (Conway, McCracken & Pretty, 1987). This matrix enables planners to decide the priority upon which to place suggestions for future actions. In the context of urban health, each intervention can be examined for the following characteristics:

- health benefit (what is the overall health impact?);
- community capacity (how committed is the community to solving the problems and what can they contribute to their solution?);
- sustainability (can the intervention be maintained and at what cost?);
- equity (which income groups are likely to benefit most?);
- cost (what are the initial capital and manpower costs?);
- time for benefit (how long will it be before changes are noticeable?).

Each intervention is scored by giving "+" for low, "++" for medium and "+++" for high. The highest total score is given the highest priority. Appendix V presents the matrix with some examples from a case study where rapid appraisal was used.
5. DEVELOPMENT OF A PLAN OF ACTION

5.1 DEFINING PRIORITIES AND ACTIVITIES

5.1.1 The Final Report

The purpose of collecting and analysing data by rapid appraisal is to develop an information pyramid for a plan of action for urban health improvement based on community-defined needs. The basis of the programme is the final report of the team. This report should consist of:

I. An introduction and overview of the municipality under study

II. A review of major urban problems in the municipality

III. The findings of the rapid appraisal based on the documents review, the key informant interviews and observations

IV. Recommendations

V. Plan of Action

The most useful form of report consists of a fairly short summary of the findings and an outline of implications of these findings for future action; this comprises the main body of the document. The details of the interviews and the final summaries can be placed in an appendix.

The report should be made available to all those who participated in the interviews. If funds are not sufficient to send each informant a copy of the report, a one-page summary can be sent, with information indicating where a full report can be seen.
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Credibility and cooperation for the future programme depends on giving back a digested summary of the information taken from key informants.

5.1.2 The Planning Process

The report, based on the information pyramid, becomes the basis for the next step in the planning process. This step is to call together members of the interviewing team and a small number of key informants to review the findings of the report and suggest future actions.

There are several planning methodologies which might be used. It is not possible to review alternatives here. However, it is important to stress that, because the purpose of the entire exercise is the use of a primary health care approach to improve the health of the urban poor and that the rapid appraisal technique, using key informants to identify problems, is the method by which to make a community-needs assessment, participatory planning approaches which involve both resource holders and community people are recommended. Community people may, thus, share with the planners both the identification of problems and plans for the solution of these problems (for an example of this type of methodology, see GTZ, 1987). If professionals alone identify and attempt to solve community problems, then it is quite possible the professionals will find themselves having to gain the compliance of a passive community, as well as carrying the entire burden of costs.
5.2 DOING A DETAILED HOUSEHOLD SURVEY

The problem(s) identified in the rapid appraisal and the action selected for solving these problems may demand more details and quantitative information. At this stage of the planning process, it is necessary to know not merely what the problems are, but how big they are. In other words, it is now time to obtain a good approximation of how many people are affected by this problem and what resources are available between municipal authorities, community people and nongovernmental organizations to solve these problems.

Doing a detailed household survey at this point in the planning process, rather than as a preliminary step, is important for several reasons. Firstly, the survey can be well targeted to priority problems which have been defined by the rapid appraisal. Hence a more limited survey is required, which can be conducted more quickly and with less resources, than would otherwise be the case. Secondly, as the rapid appraisal will have involved the community in prioritizing problems for action, the community will be more inclined to recognize the important of information for planning and be more prepared to give its support to the survey.

When more quantitative information is required for a project based on the rapid appraisal, conducting a detailed survey to obtain this information can be included as an early activity in developing a plan of action. This strategy will enable project funds to be allocated for the survey, which might otherwise not be feasible on financial grounds.
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For defining major health problems, there are a range of public health techniques planners can draw upon. These include standard epidemiological sample surveys and case studies (Casley & Lury, 1987). For estimating childhood mortality, a number of new methods are now available for use when vital registration and census data are inadequate (Hill & David, 1988). A very good approach to designing and carrying out a detailed household survey can be found in another WHO publication, entitled "Improving environmental health conditions in low income settlements: A community-based approach to identifying needs and priorities" (WHO, 1987). It begins by providing a general explanation about the problems of urbanization and environmental health as general background information. It discusses methods of carrying out a detailed community survey and includes, in the appendix, useful technical information about designing questionnaires, choosing sampling methods, training interviewers and coding and cross-tabulating results.

5.3 PLANNING FOR MONITORING AND EVALUATION

Monitoring and evaluation are closely related, but distinct, activities (UN ACC Task Force, 1985): they have different purposes and usually involve different people:

- Monitoring is an internal project activity to enable managers to implement a project in an efficient manner. It involves managers in review and surveillance of the implementation of project activities to ensure that they are proceeding according to plan.
Evaluation examines more fundamental questions concerning the continuing relevance of a project and the appropriateness of its objectives and strategies are examined in the light of experience; evaluation usually includes individuals not directly concerned with project implementation.

Because of the process of designing and implementing health development projects is complex, the impact of many projects has been disappointing. Monitoring and evaluation provides an opportunity for learning from and improving a project as it proceeds; it is an essential component in the implementation of a project and can be a key contributing factor to its success. Hence, provision for monitoring and evaluation should be included in the plan of action.

The understanding of monitoring and evaluation as a learning process for all involved in a project implies that these activities should be as participatory as possible (Feuerstein, 1986). Involving community representatives in the process of monitoring and evaluation can lead to a better understanding of the activities, an awareness of the constraints, and continued participation and support for the project.

Monitoring and evaluation involves the use of indicators to measure, or "indicate" changes in a situation. The selection of useful indicators is not easy and requires that the objectives of the plan of action, or project, are specific and stated with clarity. A plan of action need not prescribe indicators in detail, but it is necessary to provide suggestions on key
Guidelines for Rapid Appraisal

aspects to be monitored: the results of the rapid appraisal can be used to identify these. Indicators must also be kept to a minimum; when this is not done, the collection and processing of the data, both qualitative and quantitative, required for producing indicators can consume an excessive amount of resources. The information generated by the rapid appraisal and by the baseline survey, when one is included in a plan of action, provide useful reference material for monitoring the effects of a project and evaluating its impact.
APPENDIX I

TIMETABLE FOR THE TEN-DAY RAPID APPRAISAL PROCESS

1. Pre-planning

- Contact facilitator
  It may be necessary to do this two months or more before the date of the workshop, to ensure that the facilitator is available when required.

- Identify and contact participants
  At least one month before the workshop.

- Arrange venue for the workshop
  Probably several weeks in advance.

Do not forget to prepare a budget and arrange funds for holding the workshop and for the rapid appraisal as a whole.
Guidelines for Rapid Appraisal

2. Workshop Outline

DAY 1

Introduction
- Introduce workshop and participants
- Review of urban health problems
Introduce purpose and methodology of rapid appraisal
- 5 hours

DAY 2

Use of the information pyramid to develop a checklist for data collection
- 8 hours

DAY 3

Identification of data sources (documents, key informants, observations)
- 2 hours
Prepare plan of action for data collection
- 1 hour
Practice skills in semi-structured interviewing
- 5 hours

DAY 4

Document scan
- 4 hours
Field interviews
- 4 hours
Appendix I

DAY 5

Field interviews (continued) - 8 hours

DAY 6

Field interviews (continued) - 4 hours
Data Analysis - sort the data collected and agree the major health problems - 4 hours

DAY 7

Data Analysis (continued) - 4 hours
Field interviews to find the priority the community places on the problems previously identified - 4 hours

DAY 8

Finalize analysis and report of findings - 4 hours
Definition of priorities - 4 hours

DAY 9

Definition of priorities (continued) - 4 hours
Preparation of Plan of Action - 4 hours
Guidelines for Rapid Appraisal

Appendix I

DAY 10

Finalization of draft workshop report and preparation for presentation of report to community leaders and municipal authorities - 4 hours

Presentation of report - 2 hours

Amend workshop report in light of feedback from the presentation - 2 hours
APPENDIX II

TIMETABLE FOR EXTENDED RAPID APPRAISAL PROCESS

1. Pre-planning
   See Appendix I

2. Introductory Workshop Outline

   DAY 1
   Introduction - 3 hours
   - Introduce workshop and participants
   - Review of urban health problems
   Introduce purpose and methodology of rapid appraisal - 5 hours

   DAY 2
   Use of the information pyramid to develop a checklist for data collection - 8 hours

   DAY 3
   Identification of data sources (documents, key informants, observations) - 2 hours
   Prepare plan of action for data collection - 1 hour
   Practice skills in semi-structured interviewing - 5 hours
Guidelines for Rapid Appraisal

3. **Data collection**
   
   Plan of action agreed in the introductory workshop implemented.

4. **Final Workshop**

   **DAY 1**
   
   Finalize analysis and report of findings  - 4 hours
   Definition of priorities  - 4 hours

   **DAY 2**
   
   Definition of priorities (continued)  - 4 hours
   Preparation of Plan of Action  - 4 hours
APPENDIX III

DATA FOR INFORMATION PYRAMIDS

1. BUILDING THE BASE: INFORMATION ABOUT COMMUNITIES

As explained in Section 2, rapid appraisal is the basis for the development of an information pyramid to create plans of action for improving the health of low-income urban people. To reiterate, the base of this pyramid is built on information about community structures, interests and capacity to act; the next level on information about the environmental, socioeconomic and disease and disability features; the third level on the existence, coverage, accessibility and acceptability of health, environmental and social services; and the final level on government policies. The pyramid implies that planning must be built on a strong community base. Below are areas which have been identified about which information may be useful and the reasons why this information might be useful. TO REPEAT, IT IS NOT NECESSARY OR USEFUL TO HAVE INFORMATION ABOUT EACH TOPIC, IT IS IMPORTANT TO BE AWARE THAT EACH TOPIC MIGHT PROVIDE INFORMATION TO HELP YOU MAKE A GOOD PLAN OF ACTION. It is the quality not the quantity of information that is important.

In the description below, the discussions about information at the community level are less detailed than those of the discussions about the environment and service provision, despite the fact that more information is needed. The apparent contradiction is because relevant data about communities depends on
Guidelines for Rapid Appraisal

Appendix III

the situation in each specific community. It is not as easily divided into defined categories as is data about socioeconomic status, or about service provisions. Much of the community data will be collected through discussions and observations. Information will provide a general assessment of community structures and capacities, rather than specific data about one area. It is the general description and the analysis based on this description that forms the base of the information pyramid.

1.1 COMMUNITY COMPOSITION

It is important to identify the major groups in the area and to define their common interests.

Low-income urban communities are most often composed of different linguistic, tribal and/or cultural groups, often sharing only a common geographic area and a struggle for scarce resources. For the information pyramid, it is important to define the groups which compose that community, to see which groups share interests, to identify which groups are dominant and which have least access to the few resources and to understand why this may be so. Competition among groups should also be noted and leaders identified from various factions.

1.2 COMMUNITY ORGANIZATION AND STRUCTURES

It is important to describe the structure of the community and the types of organizations which appear in the community and to identify whose interests they represent.
Appendix III

People living in the same geographic area develop some type of structure and organization which defines relationships with each other. Community structure is the description of groupings in the community. Examples of these include social class or caste, level of education, type of employment and income levels. Organizations are the way in which these groups formally develop and support activities. Organizations may be supported by the national government, as in countries like China and Tanzania, or may be developed where strong families or alliances form to exercise some control over life in the community. Examples of organizations are the national political party organizations of socialist governments, women's organizations, voluntary and nongovernmental organizations and charities like the International Rotary Clubs. Organizations and structures can either help or impede the introduction of new ideas and activities in a community. They also facilitate or impede assistance and support given to more marginalized people.

1.3 COMMUNITY CAPACITIES

It is important to make some assessment about the capacity of the community to mobilize, organize and support a common set of objectives.

Community capacity to take action on problems which affect their lives depends on the strength of the existing organizations, the role of community people in managing community-based programmes, their participation in defining priorities for community programmes and their ability and willingness to
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contribute personal resources to community activities. Understanding community composition, interests and structures and identifying the types and strength of community organizations, will help determine the capacity of the community to take action for health improvements. As the success of programmes depend on this capacity, the better it is understood, the greater the chance that plans will achieve their objectives.

2. DESCRIBING THE ENVIRONMENT AND THE DISEASE BLOCKS

At this level we are concerned to develop a profile of those aspects of the community's environment which have major implications for health. Of most importance are:

- the physical environment, particularly housing, water, sanitation, solid waste disposal and locational features;
- the socioeconomic environment, particularly job opportunities in the formal sector, employment of children, non-formal work and cultural/historical traditions that promote or hinder good health;
- disease and disability, particularly the prevalence of malnutrition, communicable diseases, trauma, high fertility, maternal mortality, physical and mental handicaps and chronic problems due to pollution and stress.
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2.1 THE PHYSICAL ENVIRONMENT

The quality and availability of housing should be described.

The range in the physical structure of houses should be noted. The most recent, and least substantial, are likely to have least amenities, though they may be less crowded than long-established down-town tenements. The adequacy of physical structures should also be assessed in relation to prevailing climatic conditions.

There may be a substantial number of the "residents" of settlements who have no house and live in the open. This will give an indication of the adequacy of provision of housing, which can likewise be assessed by the numbers of individuals, or families, sharing a room. It is important to clarify the legal status of residents in tenements and settlements, as this influences residents' motivation and ability to work for improvements in their living conditions. Some people may:

- have full legal ownership of their dwelling;
- hold possession "rights";
- rent their property, under a variety of arrangements from a range of owners.

Settlements themselves may not "exist" legally and thereby be excluded from entitlement to municipal services or protection from summary dissolution. Such circumstances can create a sense of insecurity, powerlessness and hopelessness in a community and expose it to exploitation by unscrupulous persons.
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Whether there is accessibility to a sufficient water supply of reasonable quality should be investigated.

The water available should be sufficient for drinking, bathing, food preparation and domestic hygiene. Where the sewage system is dependent on water, a large flow will be essential to keep the system operational. Sufficient water of reasonable quality for drinking is particularly important. A piped system may have low pressure and intermittent supply; its accessibility is influenced by whether it is connected to each house or individual dwellings within buildings, or a community tap. A majority of households may rely upon purchasing water from a vendor and the price may be exorbitant. Some may rely on rain water, others on waste water.

Where a piped system exists it may be inadequate for a variety of reasons; these include absolute scarcity in relation to the numbers to be served, preferential supply to privileged sections of the city, illegal connections to the system. The latter can also lead to contamination of the water and wastage through leakage. Where the public water system is inadequate, the community may lack the motivation to maintain it.

The methods of excreta disposal should be enumerated with an indication of the prevalence of each. If plans exist to introduce improved methods, either by the municipality or landlords or by community effort, these should be noted; are the plans likely to be implemented and in what time frame?
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Common methods for disposal of human excreta are: wet and dry pit latrines, overhung latrines, "wrap and carry" defecation trenching grounds, defecation in open drains — all of these methods are inadequate. In long-established, inner city tenements, or in settlements where improvements have been undertaken, water-carried sewage systems may exist, either in individual houses or for communal use. The adequacy of the means for solid waste disposal should be assessed.

Solid waste is often a fire hazard. Its accumulation can block drainage channels and thereby help create standing water and breeding sites for disease vectors and rodents. Settlements may be totally lacking in efforts at solid waste management, with indiscriminate disposal of refuse by residents and non-existent services. Alternatively, community practices may serve to minimize the accumulation of solid waste and this can be complemented by some service provision.

The level of standing water in the community should be examined.

Standing water is a hazard as a breeding site for disease vectors and, if substantial, to very young children; it also has considerable nuisance value for residents. It can arise from a total lack of drainage, or from drains blocked by general rubbish, or because they have been "converted" to sewers. A determinant of water stagnation is the geographical location of a settlement.
Does the geographical location of a settlement create health hazards?

The situation of settlements may predispose them to flooding from nearby rivers, or from monsoon rains. Those built up hillsides may be liable to landslides, particularly during the wet season. The extensive rubbish dumps which often accommodate settlements and which may be a source of income, also contain hazards ranging from broken bottles to considerable accumulation of toxic wastes from industry.

Factories producing heavy industrial and toxic items, without adequate safeguards, are hazardous to health, both as regards general environmental pollution and the risk of industrial accidents. Identification of these risks is important; it may be possible to render the factories safer, as the community may value the proximity of the opportunities for work without the expense of travel.

2.2 THE SOCIOECONOMIC ENVIRONMENT

2.2.1 Education

The general level of education should be assessed and opportunities for further education be described.

The levels of literacy and the opportunities which exist for people to become literate in a community, are significant for the creation and maintenance of self-reliance and hygienic standards. In relation to the care of young children, female literacy is most important. However, good standards of adult
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literacy in general improve a community's organizational capacity and provide the possibility of access to a wider range of jobs.

2.2.2 Economy

The means of cash income should be explored.

In contrast to most rural communities, the physical survival of urban dwellers depends on a cash income; the adequacy of that income will be a major determinant of the quality of life. The means by which cash is obtained will also have important repercussions on the health and social welfare of individuals and their communities.

The employment opportunities available for both men and women are limited by a number of constraints. The absolute availability of work in the city is the major constraint. Available work may not be accessible for a variety of reasons: the cost of transport, inadequate levels of education, insufficient appropriate skills. Child labour exploitation will have serious effects on the health and development of the children, while excluding adults, who are more expensive to employ, from work opportunities.

A major source of cash is often reprocessing the discarded surplus of industry and the privileged classes. Obtaining sufficient cash for a family to live from such work will involve most members of the family in scavenging and processing "waste" during the daylight hours. Shoe-cleaning, car "watching" and a
host of similar informal jobs may be a means of obtaining cash for a significant number of individuals and family units.

The only means of earning cash for food for many, will mean engaging in illegal activities, which may or may not be socially detrimental to the society as a whole. Examples include begging, prostitution and involvement in illicit drug networks.

2.2.3 Child welfare

Gaining a sense of child welfare can be important.

Generally, inadequate environmental conditions and extreme poverty, in close proximity to affluence, can increase risks for the well-being of children. In addition to child labour exploitation, the sexual exploitation of children, both male and female, for financial gain may be widespread. General child abuse may also be a significant and increasing problem in many urban situations. A cloak of silence may cover these matters, but they are needs which must be identified and addressed (WHO, draft).

2.3 DISEASE AND DISABILITY

It is important to identify the major disease problems in the community and describe the causes of these problems.

While clinic records may give some evidence of these problems, they are often a questionable source of information. For instance, they may be inaccurate or they may not indicate the areas which people come from. They reveal nothing about people who seek care from other places, or cannot afford to seek care at all.
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Below are some of the diseases about which information might be sought. Observations and interviews should provide data which, when combined with discussions with health staff and an examination of clinic records, will present a picture of disease problems in the community.

2.3.1 Malnutrition

Malnutrition is not only a major childhood disease in its own right, but is also a co-factor in other diseases, particularly infectious diseases. Identification of malnutrition as a problem and a crude assessment of its prevalence is of particular importance, as it may not have been recognized by the community or accorded a high place in their list of problems. Night blindness, from vitamin A deficiency and anaemia may be particularly nutrition-related problems, where practical intervention is most possible. Among the most deprived urban dwellers, severe degrees of general childhood malnutrition may be common.

2.3.2 Communicable Diseases

These largely preventable diseases remain the major immediate causes of morbidity and mortality, particularly among children. Diarrhoeal disease is probably the most important disease complex in urban settings; it is a particular hazard to young children, especially those who are malnourished. Measles epidemics of large magnitude are liable in the overcrowded housing conditions. The deformities to which poliomyelitis gives rise, are particularly liable to create handicaps in the
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marginal existence of urban slums. Tuberculosis remains a major, and often increasing, cause of morbidity and premature death. Venereal diseases, which also infect children, may be common, with AIDS (Acquired Immune Deficiency Syndrome) a particularly lethal hazard. Malaria may not officially "exist" in the city and yet be a common disease for the urban inhabitants.

2.3.3 Trauma

The physical and social conditions of the urban environment and the stress which they create, increase the risk of suffering physical trauma and diseases associated with stress. The prevalence of accidents among children, and young adults in particular, in the home, at work and on the road may be a cause of significant concern in a community. Trauma from violence, perhaps related to crime, may also be a concern. In settlements more recently formed, or those with particularly mobile populations, anxiety and other disturbed mental states may be a significant, but unrecognized, burden for many. In longer-established settlements and among the more wealthy members of urban communities, cardiovascular disease can be an important cause of ill-health, affecting middle-aged men responsible for earning cash for family survival.

2.3.4 Women’s Health

In a relatively high percentage of urban families a woman, often as a single parent, may have prime or sole responsibility for the family’s survival and well-being. Many women will spend
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Long hours in low-paid employment in addition to their work in the home; they will be undernourished; exposed to the risk of venereal diseases and/or frequent pregnancies, with the risks of illegal abortion or poor care at childbirth. Their particular concerns and needs should be addressed, not just for their benefit, but because their health will largely determine their capacity to care for the children.

2.3.5 Chronic and degenerative diseases

The elderly urban population is rapidly increasing and is vulnerable to diseases which are likely to go unrecognized. In urban communities, it is necessary for elderly people to be more self-sufficient than is usual in traditional rural environments. But the characteristic diseases from which they are prone to suffer - for example, heart disease, stroke, diabetes, arthritis, senile dementia - reduce their mobility and capacity to provide for themselves. The worst effects of some of these diseases - such as high blood pressure leading to a stroke, diabetes leading to gangrene and amputations - could be prevented or minimized.

3. Assessing Service Coverage

3.1 Health and Environmental Services

Service provision needs to be assessed at the community, primary health unit and hospital levels to investigate service accessibility, affordability and acceptability in order to obtain an overall assessment of health service coverage for urban communities.
3.1.1 Service Provision

A direct relationship does not exist between physical proximity to health facilities and the delivery of services to, or the uptake of services by, a community. Nevertheless, the identification of the various health and environmental services which exist in a community, or are said to be provided for a community, is a necessary starting point for assessing service coverage.

Simple enumeration of health facilities, however, is an insufficient assessment of service provision. The orientation of service outlets and the identification of the service mix are also important. Are services predominantly curative, or primarily promotive and preventive, with the necessary curative and rehabilitative provision? Is the orientation and mix of service outlets appropriate to the health needs of the population? Or, taken together, do all of the health and environmental services available to a community attempt to meet that community's needs for: "promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries" (WHO, 1978, p. 53).
the needed intervention. Some services which are "said to exist" may be effectively non-existent because of poor quality; in some cases health services may be detrimental to health!

The availability of staff during working hours and their attitudes to patients and other clients need to be considered. The adequacy of basic equipment and sundry supplies will influence the quality of many aspects of health care. The supply of drugs, at affordable costs, may determine whether patients come at all. The quality of the service is closely related to service mix (see above). (The knowledge and technical skill of staff is of vital importance, but it is not easily assessed other than by direct methods.)

3.1.4 Service Organization

The organization of health services is crucially important for promoting equity and ensuring effectiveness and efficiency in their provision to the community as a whole. Is good use being made of the available resources for the health of the whole community and not just for privileged groups? Are health and related services planned and provided in a collaborative and coordinated manner? Do mechanisms exist for assuring quality without unduly limiting opportunities to provide services?

3.2 SOCIAL SERVICES

A review of the other existing social services available in the community should be undertaken.
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Among the urban poor are vulnerable groups for whom a network of educational and social services are necessary, in order that their lives may be tolerable and they can contribute to the community, rather than be a drain on the community's scarce resources. The particular circumstances of urban communities require a range of services much broader than have usually been considered. The need for educational services for children is likely to be recognized, even though the service is non-existent or very restricted. But the existence of avenues for non-formal and functional education are at least as important as the availability of primary education for children.

Other essential social services include:

- day-care services for the pre-school children of working mothers;
- rescue and shelter services for abandoned children;
- recreational facilities for children and youths;
- counselling and support services for pregnant girls and for children and youths involved with drugs, prostitution and other forms of abuse and exploitation;
- rehabilitation services and shelter for elderly people who are no longer self-sufficient.

4. IDENTIFYING HEALTH POLICY

The investigation of policy and legislation should explore whether there is the political will to pursue the principles of equity and justice.
The Member countries of the World Health Organization have endorsed the report of the International Conference on Primary Health Care in Alma-Ata and officially adopted the Global Strategy for Health for All by the Year 2000. This commitment has not been translated into detailed government policy in all of the countries, but many have outlined the interest of the Government with regard to programmes in the health sector. In this context, it is important to realize that the commitment to PHC on the part of Governments applies to the urban, as well as to the rural, populations — and the concepts of PHC are likewise applicable to urban health systems. Thus, the first step in identifying urban health policy is the investigation of the extent to which the Government’s endorsement of the PHC Strategy has been translated into official policy.

If a current national health policy document or plan exists it should be examined with regard to its stance on the urban health system. While it may concentrate on the health of the rural population, it will also have great relevance for urban health planners. There may be a health plan for the municipal authority, or a former plan may contain useful background information on the evolution of local government policy in relation to health.

Many countries will have a Public Health Act, often of long-standing, and frequently with outdated and unnecessarily restrictive regulations. Yet, these very regulations may be a stumbling block for the municipal authority as it attempts to respond to the needs of the rapidly expanding population in the
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city and the urban poor in particular. Alternatively, there may be clauses which, if implemented, could provide opportunities for new resources to address the most pressing needs. In some countries, modern legislation may discriminate in favour of the poor and make it possible for them to improve their environment.

Investigations should extend beyond the confines of health policy and enactments alone, to encompass the important health-related problems of, for example, land rights. They should also include an analysis of budgets, to see if the promised funds have been allocated to primary health care activities.
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APPENDIX IV

A DESCRIPTION OF THE MODIFIED DELPHI TECHNIQUE

Health managers, particularly in the field of manpower planning, have had some success in understanding problems by using a modified Delphi technique\(^1\) (A. Levine, 1984; R. Gala Morere et al., 1980). Combining sociological and anthropological approaches with investigator assessments based on professional experience, this method uses key informants (such as officials, health service personnel, teachers, community leaders, etc.) to identify existing problems and potential solutions (see Section 4.2.2.2).

The modified Delphi technique uses professionals, bringing personal skills and knowledge (in urban settings members of various municipal offices have proved effective) to form a team to decide on which key informants should be interviewed, how and what questions should be asked and how information should be analysed. It is important to have a multisectoral team, both because of the wide range of experiences each brings to the problems, and because of the need to draw upon a range of sectors to find solutions. The team undertakes an initial survey, records the results and then returns with these results.

\(^1\) The term derives from the ancient Gracian oracle who lived in Delphi forecasting the future. The idea here is that by asking informed persons they can give insight as to how the future of a specific plan might best succeed.
to the key informants. By requesting their views a second time in the light of the results, it is possible to seek information about ideas which have been expressed but do not accord with the general findings and to seek a consensus about priority community problems. It has the added benefit of providing rapid feedback to key informants. After both sets of data are reviewed, a plan of action is formulated.
### APPENDIX V

**PRIORITY MATRIX**

<table>
<thead>
<tr>
<th>Values</th>
<th>Health Action</th>
<th>Every house to have a latrine built by the family</th>
<th>Provision of roads</th>
<th>Construct refuse bays and garbage collection</th>
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</thead>
<tbody>
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<td>Health benefit</td>
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<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>Capacity for self-help/participation</td>
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<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>Sustainability</td>
<td>***</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>Equitability</td>
<td>***</td>
<td>++</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
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<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
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<td>+++</td>
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REFERENCES


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