LEARNING MATERIAL TO ASSESS AND PLAN

Based On

THE TRAINING WORKSHOP ON
HEALTH SYSTEM REORIENTATION
IN URBAN AREAS TO REACH THE UNDERSERVED

LUSAKA, ZAMBIA
17-27 April 1989

Sponsored by:
DANISH INTERNATIONAL DEVELOPMENT AGENCY
and
WORLD HEALTH ORGANIZATION
# LEARNING MATERIAL TO ASSESS AND PLAN

Based On

THE TRAINING WORKSHOP, LUSAKA, ZAMBIA, 17-17 APRIL 1989

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SECTION ONE

INTRODUCTION AND OBJECTIVES FOR THE WORKSHOP

INTRODUCTION

The following document provides a description of a workshop on Urban Primary Care, together with the reference materials and educational exercises to be used in the workshop. The overall purpose of the workshop is to encourage and enable a reorientation of health-related services in urban situations in developing countries. The workshop responds to the problems caused by the extremely rapid growth of urban populations and the recognition that current policies and services are incapable of dealing with the health-related problems which this rapid growth causes.

The workshop has been developed by WHO, with support from DANIDA. The various materials were prepared and then used in a workshop held in Lusaka, Zambia, during April 1989 (see Annex I for List of Participants).

As a result of this experience a number of changes have been made and it is now felt that this document provides a useful guidance for others intending to provide similar workshops. However, it must be stressed that the key word is "guidance"; whilst it is likely that most of the teaching materials can be used with little modification, the workshop coordinator must spend time studying the various suggestions in this document and making active decisions whether to accept the suggestions or not. The responsibility for making the workshop a success must lie with the coordinator of each workshop.

OBJECTIVES

The workshop is designed to address the increasingly severe problems of providing health-related services in urban areas. There are, of course, very substantial problems due to the limited financial resources available. This workshop takes this constraint as being relatively permanent and seeks ways to maximize the benefit available from the limited financial resources. The assumption is that existing services tend to be uncoordinated and are often provided in the absence of any deep understanding of what the community really needs.

This workshop therefore provides ways through which managers can work more closely with communities, can learn effectively about community needs and then incorporate the outcomes of this process into plans for providing health-related services.

In summary the long-term objectives of the workshop are:

(i) to promote development of primary health care which emphasises equity and community development in urban areas;

(ii) to enable existing managers of health-related services to assess the basic health needs of the population, including low-income groups;

(iii) to enable existing health-related service organizations to extend their services to improve the health status of the urban population, especially the unserved and the underserved.

The contribution of the workshop towards achieving the long-term objectives outlined above is to develop the skills and attitudes of the workshop participants. In particular, at the end of the workshop, the participants will achieve the following learning objectives:
• have an increased ability to find out about the local situation with regard to the health status, health services and the social, economic and environmental factors which influence health. The process of "finding out" will involve the design of studies, collection and processing of information leading to an understanding of the local situation;

• have an increased ability to use their understanding of the local situation in planning for changes in working practice or the allocation of resources to meet identified needs. This process may involve selecting priorities, identifying alternative solutions, scheduling activities, costing and allocating resources and preparing written programmes of work to communicate intentions;

• know of examples of "good practice" in relation to Urban Primary Health Care in other cities;

• know of methods of involving the community in planning for and providing health care;

• want to find out about the local situation, to solve problems, to take initiatives and to serve and to listen to the community;

• consider longer-term objectives for development as of great importance.

The objectives for this workshop do not concern specific techniques of health care, nor the techniques of management beyond those specified above.
SECTION TWO

HOW TO USE THIS PACKAGE

As mentioned above, this package is a guide to conducting a workshop on Urban Primary Health Care. It can only be a guide and not a set of instructions since every situation is different and since those responsible for a teaching/learning process must act responsibly and take decisions about the way in which the teaching materials are used. This decision-making process has to be flexible and decisions will usually need to be adapted during the course of any period of learning.

With the above qualification constantly in mind, a workshop team can use the following materials with the confidence that they have been successfully used in one workshop.

The package consists of a series of notes on preparing for the workshop. There then follows a series of notes on how the workshop can be conducted, together with a suggested timetable. The timetable refers to various technical papers and exercises which are resources to be used during the workshop.

After the workshop, there are likely to be substantial benefits if the participants receive follow-up support. Suggestions for this are given in Section Five.

The Technical Papers and Exercises appear in Section Six. Finally, the Evaluation from the Lusaka Workshop is provided in Section Seven.
SECTION THREE

PREPARING FOR THE WORKSHOP

1. The workshop team

One way of organizing the workshop is to have the workshop team consisting of one workshop coordinator working with two local facilitators and a secretary/administrator. Naturally, other arrangements can be made, according to the local requirements but this pattern has been shown to be feasible.

The coordinator, facilitators and secretary/administrator will need to devote the whole of one week in full-time preparation and be available throughout the period of the workshop. In addition, occasional work will be required during the six months or so prior to the workshop as well as a few days afterwards [see also the section on follow-up].

After agreement has been reached that the workshop is to take place and that the funds are available the following steps are involved.

2. Selecting and inviting participants

Eighteen participants should be selected. This number gives a size of group which is small enough for each person to be involved in the activities but large enough to include a diversity of skills and approaches, as well as being large enough to have some impact in several cities. Ideally, the group should consist of six senior managers from each of three cities. Some of the managers may be from the health service itself but others may be involved in housing, water, sanitation, public health or have overall responsibility for municipal planning. Ideally, all the participants should be of similar status and have considerable authority within their urban area.

The selection will need to be made locally and probably the local facilitators will be heavily involved.

The letter of invitation should explain the overall purpose of the workshop, the provisional timing and the location. It should be stressed that this workshop is intended to lead to action and development in their cities.

3. Selecting the venue for the workshop

The venue for the workshop should ideally be well away from the workplace of all participants yet accessible to an urban area which will be used for field studies. These are likely to be conflicting criteria, in which access to a field study area is likely to be more important.

The venue should be able to provide living accommodation for all participants as well as:

(a) a meeting room about 10 m by 8 m equipped with a screen, overhead projector, flip chart, three or four tables and, ideally, seats with attached writing boards which can be easily moved into different seating patterns;

(b) a smaller room for discussions, so that the group can be split into two or three smaller groups and still be able to work without disturbing each other;

(c) an adjoining room for secretary/administrator equipped with typewriter, photocopier and telephone.
4. **Selecting the field area**

During the workshop, participants will visit a field area to study the problems there. Therefore, the area should be such that it is reasonably well defined and recognized by the local people, i.e., it should be regarded as a community within the city. It should also be a part of the city which has more problems than average (although not necessarily the area which is the poorest or has the most problems) and it should not be an area which is over-researched or frequently studied.

5. **Developing the contacts in the field area**

The local facilitators should make contacts with various people living in the field area. These may include councillors or other political representatives, health workers, business people, church leaders, women's groups, social organizations, etc. The point of establishing this contact is to ensure that during the workshop the participants will be able to meet a diversity of community representatives.

The local facilitators should, at this stage, make clear to the "contacts" that the workshop will NOT be of immediate benefit to the community; no money is available and no decisions can be made within the workshop which will lead to immediate change. On the other hand, their cooperation will be of long-term benefit as it will help the managers to better understand the nature of the problems and it will develop the skills of the participants in working closely with the community.

The role of the "contacts" in the field area is:

(i) to authorize the visit by workshop participants. In some urban areas permission will be needed and it will always be wise to have the agreement of community representatives before the participants (who are inevitably "outsiders") visit the area;

(ii) to act as guides for small groups of participants so that participants can be shown aspects of the community and can be introduced to residents;

(iii) to serve as a source of information and opinions. The "contacts" will be expected to discuss the problems and their potential solution with the participants;

(iv) to attend a review session during which the "contacts" will listen to the proposals of the participants and respond to them.

During the preparation period, therefore, suitable "contacts" must be found and their cooperation sought. The workshop team should also explain what the workshop is concerned with and the role expected of the "contacts".

It may be necessary in some urban areas to find translators. This will obviously be necessary when the participants are not able to communicate fluently with residents in the field study area.

6. **Obtaining local data**

During the preparation period, it would be helpful if the workshop team could compile a summary of statistics relating to the country and the field study areas. This should not involve any survey work but should simply be a compilation of the data which is already available to the managers of health-related services.

It is also useful to build up a file of all articles in the local press (or notes on radio or television items) which appear during the week prior to the workshop. This gives an indication of the issues which are seen to be of current importance. This file should be made available to participants during the workshop.
7. **Identifying local speakers**

Whilst the majority of the workshop is devoted to group work, there is an orientation period during the first two days. The participants do need a common basis of understanding about the nature of the local problems related to urban health. Therefore, it is desirable to have local authoritative people providing this information.

The people required may work in local government or national government; they may be involved in nongovernmental organizations associated with health or health-related issues; or they may be academics with particular interests in urban health-related issues.

The local speakers should be selected so that they can cover an appropriate range of issues and, ideally, they should be able to give experience of approaches which have been successful in the local context.

Themes which might be appropriate include:

(i) population growth and demographic change in the country and, especially, in the urban areas;
(ii) economic growth and the patterns of distribution of wealth;
(iii) the impact of poverty on the local urban populations;
(iv) the current provision of health-related services in urban areas.

The themes for the sessions must be decided locally for each workshop, taking into account the priorities as they are seen by the workshop team and the availability of suitable speakers.

Each speaker must be carefully briefed about what is expected in terms of content and style of presentation. Each speaker should be asked to provide a two to three page handout containing relevant information in a summarized form.

8. **Opening and closing sessions**

The above sessions must be carefully planned in accordance with local customs. However, it is usually valuable to involve senior people in these sessions in order to provide some status and credibility to the workshop itself and also to ensure that these senior people are aware of the workshop and have an opportunity to discuss its objectives and achievements.

9. **Providing the necessary stationery and equipment**

The following list is a guide to the needs of the workshop:

(1) typewriter
(2) access to a photocopier
(3) three reams of A4 paper for the photocopier
(4) flipchart board - 3
(5) pads of paper for flipchart - 100 sheets
(6) pens for writing on flipchart - 10
(7) Blutak or similar for fastening paper to walls
(8) ringbinder file for participants
(9) set of dividers for ringbinders - 24
(10) two reams of lined paper
(11) hole puncher
(12) pens and pencils for participants
(13) access to telephone
10. Preparing a budget

The budget will, of course, have to be prepared very early in the preparations for the workshop. The costs may vary enormously according to local factors so only the budget lines are provided here for guidance.

- Accommodation for participants
- Daily allowance for participants
- Travel for participants
- Fee for local facilitators, coordinator and secretary/administrator
- Accommodation
- Travel costs
- Daily allowance
- Hire of venue
- Travel to local communities
- Teaching materials, pens, paper, etc.
- Refreshments
- Fees for local lecturers
- Follow-up support
SECTION FOUR
CONDUCTING THE WORKSHOP AND TIMETABLE

Overall teaching/learning methods

The aim of the workshop is to develop the skills and attitudes outlined in the Objectives. To achieve these learning objectives comparatively little new on diseases or demography needs to be provided (though some will be necessary). The main thrust of the workshop will be to develop the participants' capacity to find out what is happening in their own situation and to develop their capacity to work in a problem-solving way in order to reduce the problems which they identify. To this end, much of the workshop will be spent in collecting real data, interpreting the data collected and other data which will be made available.

The style of the workshop, therefore, will be very practical in nature. The majority of the time will be spent in individual or group work on specific learning exercises. The success of the workshop will primarily depend on setting tasks for the participants which are relevant to their experiences and needs, together with the provision of incisive analytical feedback to the participants after they have attempted the tasks.

Whilst the main thrust will be concerned with ensuring that the participants have relevant experiences, some time will need to be spent in providing background technical information in the form of short lectures and Technical Papers.

A key feature of the workshop is that it should lead to action. Therefore, a significant amount of time is spent at the end of the workshop in participants preparing plans for their activities during the subsequent months.

Notes on the Outline Timetable

Arrival, Day 1

The arrival is planned to take place on the last day of the "weekend", i.e., Sunday in most countries. Participants should be greeted individually, provided with background reading (Rapid Appraisal, "Light on the Cities") and given their loose-leaf binder containing:

- letter of welcome
- provisional list of participants
- timetable
- Technical Papers 1 and 2 (other Technical Papers are distributed the night before the day when they are used)

Setting the Scene: Day 2 and morning of Day 3

The timetable for these two days is likely to need amendment in order to fit in with local needs for the opening session and with the availability of local speakers.

The aim of these two days is to set the scene, so that all participants are familiar with international issues and local problems in Urban Health. The Case Studies should give some examples of local activities which appear to be successful. The number of Case Studies is unimportant. Also, the titles for the sessions by local speakers may need to be altered.

At this stage, it is important to establish the "style" of the workshop. Participants must be strongly encouraged to question, to express their ideas and experiences and to respond critically to everything they hear; passive acceptance of lectures will be of little value.
Probably it will not be possible to complete all the exercises in all the sessions on the timetable. The workshop team will probably need to manage time very carefully and to take decisions about omitting parts of exercises.

Initial Finding out: Day 3 (afternoon), Day 4 FIELD VISIT 1

During this phase, participants will find out what issues are seen to be of major concern in the community, so that a few of these issues can be studied later in more detail. The aim at this stage is only to make a list of issues based on what people in the community say and on what the participants observe.

"Rapid Appraisal" is used as the basic technique for this purpose. The workshop team may need to make clear that "Rapid Appraisal" is not the solution to every problem and, in particular, is not a technique for planning as such; it is only a technique for finding out, in collaboration with the community, the nature of the priority problems. Other more detailed study techniques are required to investigate the problem's causes or to prepare the actual plans.

The workshop team will probably find out that it is not enough to provide Technical Papers and assume that they will be fully understood. Some further explanation is likely to be needed and, especially, participants must be encouraged to ask questions about them. However, the workshop team should not go so far as to give lectures on each topic using the Technical Papers as lecture notes.

Finding Out in More Detail: Days 5 and 6 FIELD VISIT 2

The issues will be studied in more detail to determine the scope, the impact and the causes of the problems. Naturally, in the time available, this cannot be done thoroughly. The point is to involve managers in the direct process of collecting data and in the thinking processes which should underlie data collection.

The participants will work individually, or in small groups, to prepare for the data collection. They will design at least one data collection instrument and decide on the source of data. The field visits will enable the participants to observe the health-related services which are provided in the community, the way in which the community uses those services, and the problems which the devices are designed to overcome.

Critique of Current Plans and Strategies: Day 7 (morning only)

This session will build on the report of the field visits. It will allow the participants to compare three things:

- the health needs of the community;
- the way in which the community responds to these needs;
- the provision of health-related services.

This comparison will allow the participants to estimate the extent to which the health-related services make the most effective use of the available human, physical and financial resources. The end-point of this session will be a restatement in much more precise terms of the nature of the problems which managers of health-related services have to solve.

Planning Methods - Review of Techniques: Day 9

This day will be primarily didactic and be concerned with presenting a variety of planning methods which together form the planning process. The techniques are:

- defining objectives/targets;
- quantifying resource requirements;
- assessing costs and benefits;
• identifying management constraints and opportunities;
• identifying resources in the community.

As far as possible, the workshop team should make this day active with participants doing work based on the Technical Papers. No specific exercises after Exercise 10 are provided. However, the team should ask groups to work on their key issues in order to prepare a schedule, or in order to identify resources, etc.

Preparing Plans: Day 10

Groups from each of the urban areas will use the information gained from the field visit and the techniques from Day 9 to prepare their own plans for what should happen in the field visit area. These plans will be submitted to community representatives for their reaction.

The timetable is left very open since it is impossible to predict how different groups will react. The workshop team have a major role to play in supervising group work, ensuring progress is being made sufficiently quickly and in encouraging groups to complete their plans on time.

Implications of the Techniques Learnt So Far: Day 11 (afternoon)

This session is primarily to review the experiences of the workshop to date. The aim will be to identify general lessons learnt, rather than specific techniques.

Preparing Plans of Action: Days 12 and 13

The "Plans of Action" on Days 12 and 13 are for the work which the participants will do or organize during the next few months. The plans will be concerned with the data collection and with the ways in which the communities will be involved in the planning process; they will not be plans for introducing new services.

The workshop team will again have a major role in providing tutorial support in helping groups to complete their plans to a suitable standard on time.
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SUGGESTED TIMETABLE

DAY 1
Arrival at workshop venue. Distribution of workshop manual and background reading.

DAY 2
09.00   Registration
10.00   Opening session
10.30   Break
11.00   Introduction of participants and workshop team
12.00   Objectives and methods of the workshop
12.15   Urban Health - The international perspective (Technical Paper 1 and Exercise 1)
13.00   Lunch
14.00   National population trends - local speaker
15.15   Break
15.45   The nature and consequence of urban poverty - local speaker
17.00   Close

DAY 3
09.00   Case Studies - introduction to Exercise 2
09.10   Case Study 1 - local speaker
09.40   Case Study 2 - local speaker
10.20   Case Study 3 - local speaker
11.00   Break
11.30   Exercise 2
13.00   Lunch
14.00   Introduction to Rapid Appraisal (Technical Paper 2)
14.30   Selection of potential issues (Exercise 3)
15.15   Break
15.45   Preparation for field visit 1 and interview methods (Technical Paper 3 and Exercises 4 and 5)
17.00   Close

DAY 4
09.00   Field visit 1. Identifying general problems in the field visit area
13.00   Lunch
14.00   Review of field visit - discussion led by workshop team
15.15   Break
15.45 Identifying issues for further study (Technical Paper 4)
   • Delphi and Nominal Group Technique (Technical Paper 5)

17.00 Close

DAY 5

09.00 Further investigation of issues (Technical Paper 6)
   • Identifying key questions for study

10.30 Break

11.00 Observation techniques (Technical Paper 7 and Exercise 6)

12.00 Questionnaire techniques (Technical Paper 8 and Exercise 7)

13.00 Lunch

14.00 Planning the second field visit (Technical Paper 9)

15.15 Break

15.45 Preparation and reproduction of study tools

17.00 Close

DAY 6

09.00 Field visit 2

16.00 Review of field visit 2

DAY 7

09.00 Presentation of field visit reports (Exercise 8)

10.15 Break

10.45 Criticism of current plans and strategies (Exercise 9)

13.00 Close

DAY 8

FREE

DAY 9

09.00 The need for objectives and targets (Technical Paper 10 and Exercise 10)

10.30 Break

11.00 Identifying constraints and resources (Technical Papers 11 and 12)

12.00 Lunch

13.00 Scheduling (Technical Paper 13)

17.00 Close
DAY 10
09.00  Costing (Technical Paper 14)
10.30  Break
11.00  Preparing plans (Exercise 11)
       - Continued in the afternoon

DAY 11
09.00  Discussion of plans with the community (Exercise 12)
10.30  Break
11.00  Revision of plans (Exercise 13)
12.00  Lunch
13.00  What are the implications of what has been learnt? (Exercise 14)
17.00  Close

DAY 12
09.00  Preparation of group plans of action (all day) (Exercise 15)

DAY 13
09.00  Preparation of group plans of action
12.00  Lunch
13.00  Evaluation of the workshop
14.30  Break
15.00  Closing session
SECTION FIVE

FOLLOW-UP

The short-term output of the workshop is an increase in certain skills and a plan of action for what will be done in each of the urban areas represented at the workshop. By the close of the workshop it is likely that each of the groups will have a degree of enthusiasm for actually putting these plans into effect and the workshop will only be successful if these plans are indeed implemented.

However, when the participants return to their work and encounter the routine problems which have accumulated during their absence, it is likely that the enthusiasm will diminish. To help the participants accomplish what they planned, follow-up support is required. It is suggested that the following support is provided:

(i) shortly after the workshop, a letter is sent to all of the participants with a typed copy of their plan of action. The letter should remind participants of the value of putting their plan into effect and also explaining that a postal evaluation of the workshop will take place in six months' time when they will be invited to report on their progress;

(ii) participants should be invited to submit proposals for limited funding (up to $1000, say) which will help them to implement the plans. This funding should be agreed by donors and national government as part of the original proposal for the workshop. Follow-up funding should be agreed in principle at this early stage so that when specific requests are received they can be processed rapidly. Mechanisms for transmitting funds need to be established prior to the workshop;

(iii) follow-up visits should be made to each of the participants at their urban centre by one of the workshop team. The purpose would be to discuss problems in implementing plans of action, to provide technical advice, to make some assessment of what had been achieved so far and to help motivate the participants;

(iv) six months after the workshop, a letter should be sent to each of the participants inviting them to report on what they have achieved and the problems they have faced;

(v) on the basis of these follow-up activities, plans should be devised for helping participants to keep in touch with each other and to work in continued cooperation.
SECTION SIX

TECHNICAL PAPERS AND EXERCISES
Mankind is witnessing an ever-growing urban population, particularly in developing countries. Forecasts predict that this will expand even more rapidly during the second half of this century and beyond. Factors responsible for this urban growth are rural migration to urban areas and natural increases. Urban growth and the health consequences of urbanization are increasing health problems which have become a major issue for many health and city authorities in recent years.

The total world population in 1990 will be 5.2 billion and for the year 2020 is projected to be 7.8 billion. In this period (1990 to 2020) the urban population will grow from 2.2 billion to 4.4 billion. (Graph 1)

The increased ratio of urban to rural population can be clearly visualized by comparing the years 1990 to those of 2000 and 2020. The urban population will cover 43% of the world population in 1990, 47% in the year 2000 and 67% in 2020. (Graph 2)

A comparison between the proportion of population living in the urban areas of developed and developing regions from 1970 to 2025 is shown in Graph 3. As can be seen, the increase of urban population is much higher in the less-developed countries than in the more developed world.

Health problems in urban areas

The health consequences of this rapid urban growth are generally associated with poverty. A highly concentrated, low-income population without a proper public health structure suffers the contagious diseases of rural areas, as well as those generated by the urban environment. In addition, although urban areas traditionally have had a concentration of health services and resources, these are not accessible or available to the majority of urban residents.

More specifically, many health problems revolve around the lack of housing and environmental sanitation. In the slum and squatter areas of the developing world, housing is makeshift and congested. With these high concentrations of population in small areas, environmental sanitation, like housing, is grossly inadequate. While in rural areas, the need for a water supply is greater than that of sanitation, in urban areas, because of the extremely crowded conditions and close proximity of all urban dwellers, both are equally important. Water, both in quality and quantity, is necessary for disease prevention. However, not only is clean water unavailable in the areas inhabited by the urban poor but sewage facilities and proper waste disposal are virtually non-existent.

The urban environment in which low-income people live and work has direct consequences on their health status. Diseases among the urban poor can be divided into three major categories. Firstly, there are those diseases which are most directly related to poverty which appear as a result of low income, poor living conditions, little education, inadequate diets, overcrowding and under-protection: these are gastroenteritis, tuberculosis, infectious diseases and diseases related to malnutrition. Secondly, there are diseases which are the result of man-made conditions in urban areas such as those related to air and noise pollution, traffic, stress and eating habits that lead to cardiovascular, neoplastic and mental diseases. Thirdly, there are diseases which are related to social instability and insecurity of land tenure and income such as alcoholism, drug abuse, venereal diseases and crimes of violence.

---

@ Urban growth = percentage increase in the urban population.

# Urbanization = percentage of urban to total national population.
Issues in solving the health problems

Despite the fact that cities have received more than their fair share of national health resources, these have not been allocated in either a rational or equitable manner. Indeed, in some cases national and city authorities have hesitated to provide basic services to people in unauthorized peri-urban settlements for fear of encouraging greater rural-urban migration.

Critical issues relate to rationalization of existing services, making them more accessible and relevant to the needs of the most deprived, the creation of new types of social support based in communities and creating opportunities for people themselves to play a much greater role in contributing to their own health and well-being.

Issue (i): How to reorganize the existing urban health care services

In many countries, the urban health care services are neither accessible to large proportions of the most needy population nor are they appropriate to their needs. Available health services neglect health promotion activities, including those involving environmental issues. Health personnel often lack motivation and their attitude towards the poor is often harsh. Moreover, many health care workers are not oriented towards community-based care and thus do not encourage community participation. There is also considerable evidence to indicate considerable wastage of resources, for example through relative over-prescribing, over-staffing and inefficiency.

Options for action

There is a need for more country-specific information on current urban health care organization with an emphasis on orientation towards PHC as a means of generating good examples of the changes required. More focused experimentation into methods of strengthening urban health care planning and management is also required, within the context of equitable allocation of resources not only within urban areas themselves but also the country as a whole.

Issue (ii): How to support community organization and action aimed at improving health status

The struggle for survival on the part of the very poor in urban settlements is often characterized by individual effort on behalf of immediate family members rather than well thought-out activities undertaken by communities on their own behalf. Even where elements of community organization exist, awareness about effective and feasible ways to deal with common diseases and improve health is often low.

Nevertheless, there is often a "neighbourhood awareness" generated by pressing common problems and shared poverty.

Options for action

Where community organizations exist, there is an obvious need to create awareness and interest about health and the possibilities for communities to tackle the health problems which they are familiar. Much work needs to be done to develop effective training methods for health personnel so that communities are approached in appropriate ways and are supported throughout the process from problem identification to implementation of planned interventions. There is also a need to identify appropriate mechanisms for community decision-making and action. Provision of information by municipal authorities about availability and allocation of resources is an important process in ensuring realistic expectations.
Issue (iii): Developing community-based social support services as an important contribution to health development

Poverty is the primary problem linked to inadequate health of urban poor inhabitants. The overcrowded urban environment lacks adequate public health care, potable water and sanitation. This urban environment also fosters unique urban health problems brought on by poor living conditions, unemployment, insecurity of land tenure, poor shelter, industrial pollution, crime and drug abuse. City services are inequitably distributed to urban residents.

Options for action

Wide recognition of the central importance of poverty alleviation needs to be pursued. Income-generating projects would considerably alleviate some of the health problems present in poor urban areas. Additional income for families would have a positive cyclical effect allowing proper nutrition, shelter, purchase of drugs and health care, and would reduce unemployment-related health problems.

However, broad-based community social support services are also required to complement and even facilitate poverty alleviation services such as community creches can facilitate income-generation by women whilst, at the same time, improving the nutritional status of young children. Legal advice services may prevent financial exploitation of the poor through rent control whilst the granting of legal status to recently arrived families can ensure their access to services, including health care, which they might otherwise be denied.

Innovative approaches to improving living conditions, jointly with people's involvement on critical issues such as water, shelter and environmental health, would have a sound impact on their health status.

Issue (iv): Special issues related to urban poverty

The health situation that arises from rapid urbanization truly reflects the problems of poverty. Accidents, crime, drug abuse, prostitution, abandoned and street children, and youth unemployment are among the special issues related to urban poverty, all with serious health consequences.

Options for action

In many instances, city authorities need assistance in identifying special problems and problem groups and in developing effective intervention programmes. Support in developing and strengthening policies for action is needed. Of necessity these must include a wide range of sectors. Experimentation into new approaches involving the target groups themselves, will be an important activity.
Urban Population Growth
From 1990 to 2020

Population in the Year (Billions)

Year

1990 2000 2010 2020

5.2 6.1 6.9 7.8

2.2 2.8 3.6 4.4

World Total  Urban

Graph 2

World Urban and Rural Population

1990

- Urban: 2.234 billion
- Rural: 3.012 billion

2000

- Urban: 2.498 billion
- Rural: 3.495 billion

2020

- Urban: 3.164 billion
- Rural: 4.498 billion

PROPORTION OF POPULATION IN URBAN AREAS
Developed/Developing Region, 1970-2025

Percentage in Urban Areas

YEAR


0 20 40 60 80 100

More Developed
Less Developed

"Rapid Appraisal" is a technique which has been developed to get enough information quickly. The information would normally be used in the planning process and should:

(i) identify priority problems;
(ii) give some insight into the causes of the problems and how they might be solved;
(iii) identify feasible solutions.

The Context

Planning in the past tended to collect information in one or two extreme ways. The first was to use very little data - perhaps even just the impressions and experiences of a few senior planners in the most extreme cases. The other extreme was to conduct major epidemiological studies involving many people over a long period of time. This latter extreme meant sometimes that so much effort and time was spent on data collection and analysis that little energy was left for planning solutions and putting them into effect. Rapid appraisal aims to take the middle course.

Features of Rapid Appraisal

(1) Only that data which could affect planning decisions is collected.

(2) The community is involved in collecting the data and in expressing opinions about priorities.

(3) A wide variety of sources of data and methods of data collection is used. Data is commonly collected from documents, through interviews with key informants and by observation.

(4) Rapid Appraisal is conducted by small teams of professionals, whose members are likely to have complementary skills and areas of expertise.

Limitations of Rapid Appraisal

Rapid Appraisal does not provide precise information about incidence or prevalence rates, so it is not a sufficient tool for measuring impact of interventions or monitoring their progress.

Rapid Appraisal does not give information equivalent to household surveys of opinions or attitudes. Instead, the emphasis is on finding out the views of community representatives.

Rapid Appraisal aims to bring together the perceptions of people in the community, limited quantitative evidence of actual problems and analysis of policies and resources. When these are jointly considered priority problems will be identified and potential solutions suggested.

Steps in Rapid Appraisal

The following are necessary steps to undertake Rapid Appraisal:

* For more detailed methodology, see document: "Improving Urban Health: Guidelines for Rapid Appraisal to Assess Community Health Needs", WHO/SHS/NHP/88.4.
(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.

For the first steps, the pyramid below would be useful for collecting and reviewing information:

```
         Health Policy
        /           \
  Health and Environmental Services        Social Services
    /            \                             \
Physical Environment                   Socioeconomic Environment          Disease and Disability
    /                \                          /                      \
Community Composition                Community Organization and Structure    Community Capacity
```
INTRODUCTION

The interviewer should introduce himself/herself, explain the purpose of the interview and explain what will be done with the information. Then he/she should ask whether the interviewee is willing to be interviewed.

The introduction starts by asking some questions which are non-controversial, fairly close in nature and easy to answer. This builds some confidence in the interviewee.

THE MAIN BODY

Here the real issues are discussed. As far as possible this should seem like a conversation with a friend rather than an interrogation by the secret police. The interviewer must always accept what the interviewee says (neither agree nor disagree), and add encouragement (“that’s an interesting point”) or seek clarification (“when you said ... did you mean ...?”).

During this phase, the interviewer should try to keep note-taking as inconspicuous as possible. A tape-recorder may be useful if the interviewee agrees or possibly another person takes notes of the conversation. It may be best not to write anything during the interview, but to sit down and make written notes immediately afterwards.

The interviewer must have a plan for the topics which are to be covered during the interview. This may be written on a sheet of paper and referred to during the conversation. On the other hand, confident interviewers will have the structure in mind and not need written notes.
3. Conclusions

When all the topics have been covered the interviewer should invite any further comments which the interviewee wishes to make, listen to them and then thank the interviewee for his/her time.

Notes must be made immediately after each interview.

The Process of Interviewing

Do try to use the same level of language as the interviewee's friends would use. Do smile, nod encouragement, look at the interviewee and show interest.

If necessary do bring the discussion back to the point.

Do not force the interviewee to answer a question which he/she does not wish to answer.

Do try to ask for a given piece of information in two or more different ways.

Do keep the interview reasonably short - stick to the most important points.

Do start with questions which are easy to answer, leaving more controversial or sensitive questions to the end.

Do prepare a set of questions in advance.
TECHNICAL PAPER NO. 4

Criteria for Selecting Problems

When data has been collected either by using Rapid Appraisal techniques or by other methods, then a decision has to be taken about which of the identified problems are to be solved - or which of the issues are to be considered further. The data itself cannot make this decision or tell you objectively which is the most appropriate problem to choose; you must make the decision on partly subjective grounds.

However, there are some commonly accepted criteria. These generally relate to two considerations:

(1) how important is the problem?

and

(2) how feasible will it be to solve or to reduce the problem?

Importance

This is made up of the following components:

(1) how many people are affected by the problem?

(2) how serious is the effect on each person?

(3) how do the community, the politicians, the health personnel, perceive the problem?

(4) is the problem Increasing?

Feasibility

(1) Is there any technology available which can solve or reduce the problem?

(2) Will the solution require major changes in the organization of services or the allocation of resources?

(3) Will the solution be costly in terms of money, time or other resources?

(4) Will the solution require changes in life-style of the community or the working practice of health personnel?

Using these factors does not lead to a logical objective decision about priorities - but it does make the process a little more rational.

A possible next stage in setting priorities is to rate each of the problems considered according to each of the factors. For each factor related to importance give a rating from 0 to 3:

0 - nobody is affected, or the effect is negligible, or people are not aware of the problem, or the problem is declining;

3 - nearly everybody is affected, or it causes premature death or very severe disability, or it is highly topical and everybody is very concerned, or it is an increasing problem.
Then obtain an importance quotient by multiplying the three scores. N.B. 0 times anything = 0.

For the feasibility factors, use a scale of 0 to 3 in a similar way, where 3 = no technology or very serious problems and 0 = little cost, change or difficulty in implementing a solution. Finally, divide the importance quotient by the feasibility quotient to give an overall priority score.

This process should not follow in an unthinking way - nor should the conclusions be blindly accepted. However, the approach usually leads to a constructive debate.

See also Nominal Group and Delphi techniques (Technical Paper No. 3).

A blank form is attached which can help you to record your scores.
### Setting Priorities

<table>
<thead>
<tr>
<th>Importance</th>
<th>Issue 1</th>
<th>Issue 2</th>
<th>Issue 3</th>
<th>Issue 4</th>
<th>Insufficient water</th>
<th>Overcrowded houses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number affected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seriousness of effect</td>
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<td></td>
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<td></td>
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<tr>
<td>Perception</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Feasibility

<table>
<thead>
<tr>
<th>Technology available</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization change</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Expense</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Life-style change</td>
<td></td>
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</tr>
</tbody>
</table>

### Ratio

|         |         |         |         |         |                    |                    |
These are two techniques which can be used to help reach consensus in a group of people.

Genuine consensus is difficult to achieve - yet it is very desirable, since when a group genuinely agree on a course of action they are usually well-motivated to play their part in implementing that course of action. Barriers to real consensus are the following:

(1) one or two members of the group are so dominant that the other members do not wish to oppose them even though they may not agree;

(2) less confident or less fluent members of the group are not able to express their views;

(3) discussion is so disorganized that issues are not thought through. At the end of the discussion either no decision is reached or the decision is reached more or less randomly.

These two techniques both aim to involve everybody in actively thinking through their own opinions, and in responding to the opinions of others. At the end of each process the opinions of the group members are brought together. Though these techniques help genuine consensus to be achieved they do not guarantee it; the members of the group must be willing to express their views openly and they must be willing to listen to others and respond flexibly to their ideas.

The Delphi Technique

This technique is named after Delphi in Greece where the method is said to have originated.

**Step 1**
A few groups or individuals are invited to express their opinion on an issue. In this context, they might be asked to make a list of the problems which have the highest priority. Ideally, the individuals or groups might represent different interests, e.g., a community leader, a health planner, a health worker, etc.

The groups or individuals may be in quite different places, so they never meet face to face. Or they might be in the same place. However, they will not speak to each other directly during the entire Delphi process.

**Step 2**
The chairperson then collects the views and prepares a summary of them. This might in the form: "2 people say water supply is the biggest problem, 3 people say lack of land tenure is a problem, but not the most serious ... ", etc., etc.

**Step 3**
This information is fed back to the individuals or groups, who are then invited to think about what the other people have said and either change their own opinions to coincide with the opinions of others OR put forward arguments in support of their own opinion.

**Step 4**
Again, the chairperson collects the revised views, summarizes them and feeds back the results to the individuals or groups.

**Step 5**
This cycle is repeated until there is no shift in the views expressed. At this stage, either consensus will have been achieved, or the separate interests identified.
The advantages are that all people have an equal chance to express their views and to reconsider their opinions in the light of other people's arguments. Also, because the groups never communicate directly with each other, but only through the chairperson, personality conflicts and emotional responses should be minimized. On the other hand, the whole process can take a very long time.

The Nominal Group Technique (NGT)

The Nominal Group Technique is similar to, but simpler than, the Delphi. It can be conducted with, for example, a District Health Management Team, plus some other district officials and leaders. A group of six to ten is ideal, but it is possible with more. It is a four stage process:

1. Each member of the group works alone to respond to a stimulus question, for example "list five problems which affect your daily work in health care delivery";

2. All responses are recorded on a master sheet, written up for all to see;

3. Each item is discussed briefly and clarified. Where it is agreed that items are identical, they are brought together;

4. Each participant then selects a limited number (say three to five) of the items from the complete list which he/she perceives as most important to the overall functioning of the district health service, and rank orders those items. Rank scores are then collected and areas of consensus agreed.

The advantage of the NGT is that it is quick, it allows everyone to express their opinion and if there is originally a consensus, then this emerges clearly. On the other hand, if people start with different opinions, there is no mechanisms in the NGT process through which they are likely to modify opinions and come closer together.

Both techniques are useful as ways of helping communities to participate in the process of planning health care.
By this stage, you will have had some experience in the field study area and will have decided what general issues you wish to study in more detail.

The next stage is to decide on your study questions. Some people mistakenly go straight away to making questionnaires or preparing observation checklists. This is a mistake because the broad reason for asking each detailed question can be forgotten and often unnecessary or irrelevant questions are included. You should, therefore, note down broader questions first.

These questions will centre round:

(i) what is the overall scale of the problem? (Frequency of occurrence, etc.)
(ii) what is the impact of the problem? (What consequences does it have?)
(iii) what are the causes of the problem?
(iv) what could be done to reduce the problem itself or its consequences?

You should also test each of your broad questions against the criterion ... "If you knew the answer to the question would it help managers to make better decisions or take more appropriate action?" If the answer to the question is "no" then the question should probably be left out.

With each broad study question the general method of obtaining information should be decided. Probably these methods will be observation, interviewing or the use of questionnaires. A preliminary decision about methods can be made at this stage.

The technique of interviewing has been discussed in Technical Paper No. 3, whilst observation and questionnaires are considered in Technical Papers Nos. 7 and 8, respectively.
Observation Techniques

Much can be learnt about a community and its problems by passively observing what the community is like. The key requirement of this passive observation is to allow yourself to record in your mind what your eyes are seeing - and to some extent what your other senses are telling you. To help this passive observation as many artificial barriers as possible should be removed. So, for example, it is much better to walk rather than drive; it is better to walk alone or in pairs rather than in large groups; it is better to be dressed in a similar style to that worn by other people in the community rather than in a uniform.

Passive observation is valuable, but it is probably only the start of the observation process. More purposeful observation should also be planned. For example, if you are interested in nutrition you might do some of the following:

1. see whether any food is grown around the houses in the community. If so, how much and of what type?
2. see what food is available in the markets - how much does it cost?
3. observe what food is being bought and ask how long that amount of food has to last and how many people will be fed.

On the basis of the observations you might try to work out how much food could be bought with the money available to a typical family. Would this quantity of food meet the nutritional requirements?

If you are interested in the way health care is provided, you might observe a person who is attending a health centre and record how long the person has to wait, how the person is treated by health centre staff, whether the treatment is based on an adequate history and examination, whether the treatment is explained or not, whether the person can actually obtain any prescribed drugs, etc., etc.

Purposeful observation is usually helped by having a checklist. This is simply a list of things which the observer will look for. Obviously, this is a powerful aid to observation. It can also be a hindrance since the observer will tend to only look for things on the checklist and so may ignore many other important things which were not thought of when the checklist was written. Therefore, checklists usually require development in the field. You should add to the checklist as a result of what you see during passive observation.

A checklist is usually based on a "YES/NO scale". In other words, the observer records whether something happens or not. This is obviously limited as often the quality or the manner in which something is done is very important. In this situation a rating scale is used. In this case, a series of categories are devised by the observer prior to the observation and then the actual event is assessed and recorded in one of the categories.

For example, one might observe the way in which a person is treated in a health centre using the following scale:

the person was treated: (a) rudely;
(b) impersonally;
(c) politely, but coldly;
(d) in a friendly way.
The difficulty with rating scales is to devise a scale which is sufficiently specific (so that different observers would give the same rating) whilst still being sufficiently flexible to cover all possible manners or qualities of performance.

In summary, it is very important for planners to know what is actually happening in the field rather than what should be happening. To do this, planners should always be passive observers and then for specific purposes should arrange for, and possibly carry out themselves, purposeful observation. Checklists and rating scales may help purposeful observation.
Questionnaires consist simply of a set of questions which are asked of a respondent. Usually the respondent writes his/her own answers on the questionnaire (in this case it is called "self-administered"), although it may be better for an interviewer to record the respondent's answers (e.g., if the respondent is not literate). In this case, the questionnaire is identical to an interview schedule.

There are two main difficulties in preparing questionnaires. The first is to decide what you would really like to know. The second is to write the question in such a way that it is easily understood, unambiguous and unlikely to lead to a false response.

Deciding what you would really like to know

Many questionnaire writers with less experience start off by thinking "what can we ask?". So they put down routine questions like "What is your age?", "Are you married?", "What sex", etc. These may not be relevant to the inquiry.

Especially in Rapid Appraisal, the questions must be restricted to only those lists of information which could lead to a difference in the decisions which are reached. This means that the starting point for designing a questionnaire is to think what options or decisions you might have to face. Then to think what information is needed to help you make the choice. The final stage is to think what questions would elicit that information.

Writing questions

The language used in the questions must be the language which the respondent feels comfortable with. So, if the respondent does not speak or read English very well, there is no point in using English. Similarly, few respondents speak medical jargon (or managerial jargon or social science jargon), so try to use straightforward jargon-free language.

Try to avoid "leading questions". Respondents tend to agree rather than to disagree. So questions should be stated in as neutral a way as possible.

For example, "Do you think that the service provided by the Health Centre should be improved?" is a leading question. It would be better phrased as "What do you think of the quality of service provided by the Health Centre?".

Where respondents are asked to make a choice between options, do try to make sure that all likely options are available. This will probably only be achieved as a result of field testing.

Space for responses

Many questionnaires are prepared where there simply is not enough room to write the answers - possibly in an attempt to save paper. This is clearly foolish.

Preparation for coding responses

In large-scale questionnaire surveys, it is worth spending quite a lot of time thinking about how responses will be coded and transferred to computers so that the data can be analysed. In Rapid Appraisal, the numbers involved are likely to be small, so this is not a major concern.
Rapid Appraisal identifies priority problems. However, in order to know the extent of the problem it is necessary to carry out an in-depth survey. There are many documents that describe conventional sampling methodology.* To use these methodologies the following definitions would be helpful:

**POPULATION**
A population is the complete set of people sharing some specified characteristic. For example, all male children born in George Township between 1 January 1988 and 31 December 1988 form a population. Slightly more obscurely, an attribute of a specified group of people or things also forms a population. So, "the systolic blood pressures of all male children born in ..." is also a population.

**SAMPLE**
A part of a population. Often samples will be selected carefully and according to a defined procedure. For example, a "simple random sample" may be drawn. Despite the name, it is not at all simple to draw such a sample - though the statistical processing of data from a "simple random sample" is easier than with any other type.

**PARAMETER**
A property of a population. So, for example, "the mean systolic blood pressure of all male children born in ..." is a parameter.

**STATISTIC**
A property of a sample. For example, if a simple random sample of male children born in ... is surveyed and their blood pressures measured, then the mean systolic blood pressure of the sample is a statistic.

**SAMPLING ERROR**
Sample statistics are calculated as an estimate of the population parameters. If several different samples are drawn the sample statistics will inevitably vary from one sample to another (though the population parameter of course does not).

Sampling error is therefore the error which inevitably occurs just because a sample is surveyed and not the whole population. The probable size of sampling error can be calculated and depends only on the size of the sample and the variability of the attribute which is being measured. In many ways, sampling error is easy to cope with since its probable size can be calculated.

**NON-SAMPLING ERROR OR BIAS**
This error is the difference between the statistic and the parameter which results from the way in which the sample is selected. If the sample really is a simple random sample the non-sampling error is zero. However, if the sampling has gone wrong then the size of the error cannot be known. This, of course, is very difficult to cope with, so in thorough scientific surveys great care is taken to ensure that samples are truly random (or better) so that non-sampling error is eliminated.

* Two relevant WHO publications are:

(i) Primary Health Care Review Guidelines and Methods;
Household Sampling

In addition, the points below will help in collecting information:

1. Use small samples and then find information in greater depth than would be possible for large samples;

2. Go to people who are most likely to be helpful, to have good insights into the nature of the community, to have some understanding of what solutions might be appropriate - rather than going to a random selection of people;

3. Go to places where one knows from existing data that problems are likely to be greatest. Or, alternatively, go to places where one suspects that solutions may be most effectively put into effect;

4. Use case studies to explore issues in depth;

5. Go to people who can represent the views of others;

6. Be careful not to go only to those places or to sample those people who are most accessible to you;

7. Listen to people with a variety of points of view.
Definition

An objective or a target, in the context of health management, is simply a statement of describing what it is intended to achieve. So, for example, a target could be "to reduce the Infant Mortality Rate to 50/1000 by 1995" or "to achieve a 70% measles immunization rate during the current year".

Normally, targets or objectives will specify what is to be achieved and when. However, this is not always done and sometimes actual targets are only stated in terms of "improvement", without saying how much improvement is expected.

Areas in which targets are set

Targets may relate to:

1. Health status;
2. Service provision;

(1) Health status is probably the ideal way of stating targets. For example, "to reduce IMR to 50/1000 by 1995", or "to reduce the incidence of tuberculosis to x cases per year by 1992", are both clearly stated and worthwhile targets. They both express what one is fundamentally trying to achieve. However, the difficulty with health status targets is that health is a consequence of many factors and so IMR or tuberculosis incidence rates are not directly under any single authority's control. The world price of copper may well have a powerful impact on poverty-related diseases and this cannot be controlled by health managers.

(2) Service provision is more directly under the control of health managers, so it may be more attractive to set targets in this area. For example, "for every resident of ..., there will be a fully staffed health centre available within a distance of two miles", or "antenatal care will be provided for 50% of all pregnant women".

The difficulty with these targets is that quality of service is all important, yet quality is rarely specified. Also, the provision of a service may not be sufficient to lead to improved health.

(3) Management and infrastructure targets largely relate to targets within the organization of the health service. They may relate to budgets, to the number of posts to be filled, to the training of health personnel or to changes in the regulations or procedures which control the provision of health services. The targets have the advantage of being more under the control of health managers, but have the problem of being even more remote from the actual health of people - which, of course, is the fundamental target.

The value of targets

Stating targets has a number of valuable benefits. First, if targets are communicated clearly to all involved, then a sense of purpose can be achieved amongst all people affected; they know where they are going and what they are trying to achieve. This, in turn, is motivating in a general way.
Motivation can be more specific if each person has an individual target. This technique is widely used in industry and has a powerful effect, especially if the achievement of targets leads to some reward.

Targets are especially valuable to managers. When targets are established, then it is possible to calculate the resources required to achieve these targets. Also, the targets allow managers to make effective use of much of the data which is routinely collected, since the managers can monitor progress towards achievement of the targets and take managerial action when problems arise.

Properties of good targets

Whether targets relate to health, service provision or infrastructure, they will be more valuable if:

1. they are clear - everybody involved must be able to understand what is to be achieved;
2. they are measurable - it should be possible to tell whether the target has been achieved;
3. they are feasible - there is no point in setting targets which cannot be achieved in the available time and with available resources;
4. they are agreed - all people affected by the targets should accept the targets as being appropriate and desirable.
Introduction

Even though a planned programme may be for the benefit of people in the community and be well thought out, there are all sorts of reasons why the programme may be prevented from happening or may be very difficult to implement. These reasons can be called "constraints". The point of identifying these constraints is so that one can be ready for them and, wherever possible, work out how the constraints can be overcome.

Fixed and changeable constraints

Some constraints are either absolutely fixed, or else are so difficult to change that it is not worth making the effort to try to change them. For example, in a government system, the pay scale is usually quite rigid. This may be an obstacle to appointing someone to a job and so is a constraint. Probably the pay scale itself is a fixed constraint.

Other constraints can be overcome. For example, a lack of skill can be overcome by a training programme.

It is worth spending a little time on deciding whether constraints are fixed or changeable.

Types of constraint

When considering what constraints exist, it is useful to think about the following types of constraint - though this may not cover all possibilities for every type of programme.

(1) Financial

The constraint which immediately comes to mind in most cases is the shortage of money. Whilst there may be absolute shortages of money available through one source, there may be alternative sources and even alternative financing methods.

(2) Resources

Apart from money, lack of resources such as supplies, equipment, buildings, transport, etc., may also impose constraints. Slightly less obvious are the lack of time (some health personnel may already be expected to do more work than they can manage in the time) or the lack of skill (the personnel involved may not be able to do the work demanded by the new plan).

(3) Personality

It can happen that cooperation or approval is required from a person who does have the time, skill and authority to do what is required. Yet, that person may prove to be unwilling to help. Often this is called a "personality" conflict. Yet, the basis for the lack of cooperation may be that the obstructive person is frightened or concerned at the consequences of giving cooperation or approval; perhaps there is a risk of losing power, or a fear of committing oneself to additional work, or even an underlying political or religious objection to what is being proposed.

Many "personality" constraints can be removed by trying to see the situation from the other person's point of view, by providing realistic and believable assurances and generally by meeting, as far as possible, the needs of the other person. It has
to be said, however, that this is not always enough. Personality constraints sometimes do turn out to be "fixed".

(4) Regulations/procedures

Regulations and rules within the management system can from time to time prevent plans from being implemented in the way one would like. It is important, therefore, to be fully aware of all procedures and working practices to make sure that plans are consistent with them.

Where rules do seem to present an unacceptable constraint, it is worth remembering that all rules have been made by people and so, in principle, can be changed by people. However, the process of changing rules is almost always very time-consuming and uncertain.

(5) Absence of structures

The kind of structures referred to here are organizational structures or working methods. For example, there may be no accepted way that plans can be coordinated between communities and health service agencies, or there may be no existing mechanism through which the women in a community can make their views heard.

What can be done?

The essential step is to try to identify all possible constraints BEFORE they disrupt the implementation of plans. It is not possible to see how every type of constraint can be resolved. However, it is often true that once the constraint has been identified, ways of overcoming the constraint can usually be found.
Introduction

Conventionally, most organizations tend to make plans on the basis of the resources which the organization itself has available. However, the Alma-Ata Declaration on Primary Health Care drew attention to the ideas of "Community Participation" and to the benefits which this process could be expected to yield.

The most obvious benefit is that communities can contribute to projects by paying in some way for the project or in providing labour or other resources. This makes projects cheaper. However, the more powerful benefits could be from the communities feeling involved in the project and, as a result, making more effective use of that project. For this to happen, communities cannot be treated merely as unpaid labour, but instead they must be more actively involved throughout the planning stages.

Types of community organizations which could provide resources

Social organizations
Religious organizations
Women's groups
Political organizations and Unions
Schools and teachers
Newspapers, radio
Charitable groups and nongovernmental organizations
Traditional healers
etc., etc.

Types of resources which might be available

Buildings/accommodation
Labour; e.g., to assist in maternal and child health programmes
Transport
Publicity/communication
Information: knowledge of the area and the community

How to use and identify the resources

The resources available are primarily found by talking to people in the community. Once the organization has been found, then that organization can often put you in touch with others.

Making use of organizations and their resources is more difficult. Often it will seem to take a lot of time to make all the arrangements and, inevitably, there will be a reduction in the degree of control (there are few sanctions which you can apply to people who volunteer their services). Often projects will have to be adapted to meet the needs of the community, which can be irritating, though in the long run is likely to be beneficial.
Introduction

Scheduling is rather more than just putting down a time when various activities will take place. When it is done properly it:

(1) provides an overview of what is actually intended - with all the rhetoric and jargon stripped away;

(2) provides a powerful tool for monitoring and managing a project, so that the project is more likely to be completed on time and to accomplish its objectives;

(3) provides a check that all necessary component activities have been thought of and put into an overall scheme of work;

(4) provides a basis for costing and for preparing budgets.

In view of the above, scheduling is clearly a vital stage in planning and managing projects. This stage is even more essential when projects depend on cooperation between different health-related sectors or between government and nongovernmental groups.

How is scheduling done?

Stage I - Listing the steps

Any activity consists of a series of steps. These steps are more or less complete in themselves, but also depend on other steps. For example, when a house is being built putting on the roof is a complete step in itself. But this step depends on having the walls built first, and, in turn, the roof makes other steps possible since the roof provides protection from the weather.

So, the first stage involves making a list of all the steps required to complete the whole project. Deciding what the steps are is to some extent arbitrary. Where one step ends and the next step begins is not always obvious and the size of step to be chosen cannot be defined except on the grounds of convenience. So, as a very arbitrary guide, it is usually useful to break down the overall project into between 10 and 30 steps. It may be necessary at a later stage to treat some of these steps as mini-projects and divide them further into a series of smaller steps.

When thinking of the steps, it is important to remember the constraints previously identified and to bear in mind the resources of the community. It is also important to think beyond the concrete steps, such as building a health centre or laying a pipe; things such as obtaining approval, providing training, or seeking cooperation are equally important.

At the end of this stage one should have a list of 20 or so steps of which each has a brief name.

Stage II - Defining the steps

For each step, one should think of two things, the PROCESS and the OUTCOME. For example, one step may be to obtain approval to conduct a survey. The process would be submitting a proposal to explain the purpose of the survey and attending meetings to support the proposal. The outcome would be, "the approval is granted".
Stage III - Putting the steps in order

To put the steps in order, one must think which of the other steps must come first - and which can only come afterwards. There are also likely to be some steps which could possibly be done at the same time or which could overlap.

Stage IV - Estimating time

There are two aspects to the time requirements. One is the amount of time (number of days or weeks) which the step takes. This is easy to underestimate. For example, a printer may take one day to print a leaflet. But, in practice, the printer will have other work to do, so that the total time from submitting the work to receiving the finished leaflet may be two or more weeks. So at least two weeks must be allowed for this step.

The second factor is that there are absolute dates to take into account. If approval is sought from a committee, then although the committee meeting only lasts two hours, one needs to know on which dates the committee meets. Some types of decisions are only taken once per year or every six months. The dates when these decisions are taken must be recorded.

Stage V - Summarizing on cards

A card for each step should be completed. An example of the type of card is given below:

<table>
<thead>
<tr>
<th>Step No.</th>
<th>Name of Step:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process:</td>
<td></td>
</tr>
<tr>
<td>Outcome:</td>
<td></td>
</tr>
<tr>
<td>Steps which must be completed first:</td>
<td>Steps which can only come after:</td>
</tr>
<tr>
<td>Steps which can be at the same time:</td>
<td>Total time allowed for the process:</td>
</tr>
<tr>
<td>Any fixed dates:</td>
<td></td>
</tr>
</tbody>
</table>
**Steps VI: Combining the steps in a bar chart**

In this example, Step 1 takes two months and can start on 1 May. Step 4 only takes two weeks - but can only start once Step 3 is completed, which can only start once Step 1 is completed. So Step 4 cannot be finished before the middle of September.

The steps are recorded by showing the time they take as the length of the line.

To fill in the bar chart, start off by putting as many steps as possible completely at the left-hand side, i.e. all those steps which can be started on day 1. Then steps which are dependent on other steps must come to the right of these preliminary steps. Always mark steps as far to the left as possible.

**Stage VII: Checking the bar chart**

When all steps have been put in place provisionally, go back to the cards and:

1. Make sure that all steps which must come before other steps actually do so;

2. Check that all fixed dates have been allowed for.

Then check:

1. Have any holiday periods been allowed for - or seasons when certain types of work cannot be done;

2. Is the total amount of work at any one time too much for the available resources?
(3) will the whole project be completed within the desired time period?

On the basis of this checking, revise the bar chart.

STAGE VIII - Using the bar chart

The chart gives an overall picture of what should be happening at any given time and what work should have been completed.

This allows one to:

(1) monitor progress - check that things are happening on time;

(2) adapt to delays - or more rapid progress. The bar chart is NOT a fixed document. It should be updated regularly as a result of the rate of progress made;

(3) predict the need for resources or money;

(4) predict the consequences of any delays and allocate additional resources to overcome delays if appropriate.
Introduction

Costing is obviously an essential part of the planning process. It is needed in order to find out how much the proposed activities will cost and then to compare this figure with the amounts of money actually available. Within an organization, control of the flow of funds is one of the most powerful ways in which the activities of that organization are controlled, so budgets must be submitted for approval by higher levels of authority within that organization. When interorganization or interdepartmental cooperation is involved, the amounts of money which each organization or department provides are always a key issue. If the costs are too great, or the allocation of costs between departments/organizations is not appropriate, the project will not happen. So clearly, costings are necessary.

They are more useful than just a necessary step on the way to obtaining approval, however; they provide a basis for predicting when money will be needed and in what quantities. Only if there are accurate costings of the amount of funds needed and the times when they will be needed is there any chance that delays to the project as a result of lack of funds will be avoided.

General problems in costing

A. Differences in costing methods

Although costing deals with money and numbers, it is not an exact science. For example, if a project requires a 100-mile journey to be undertaken by car, the cost can be calculated in many ways:

1. it might be "free". If the project already owns and maintains the car, employs the driver and has supplies of petrol, then there will be no additional costs. So the cost of the journey could be regarded as zero;

2. there may be a standard mileage rate. For example, the rate might by $0.50/mile. So the cost would be 100 x 0.50 = $50;

3. if no standard rate exits, then the costing process might involve adding up all the costs of transport - purchase of vehicles, maintenance costs, fuel costs, insurance, driver's salary, repairs, depreciation, etc. Then the total cost is divided by the number of miles to be travelled to give an actual cost per mile.

Clearly, the numbers might be very different, depending on the costing method chosen. Other resources where the "cost" is dependent on the costing method include the use of space in building, use of equipment which is shared and, most important, the time of people who are already employed but carry out several different functions.

B. Foreign exchange

A further complication occurs when items are to be supplied which have to be paid in foreign exchange. It may be necessary to keep costs in kwacha separate from costs in dollars.

C. Inflation

During a long-term project, the costs of services and commodities are likely to increase. However, the size of this increase cannot be known with any certainty. The usual procedure is to find out the current rate of inflation and assume that it will
increase at the same rate over the duration of the project. Suppose this rate is 10%,
then an item in the current year which costs 500 kwacha will cost 500 x 110/100 =
550 kwacha next year. The year after it will cost 550 x 110/100 = 605 kwacha. The next
year the cost will be 605 x 110/100 = 665.50 kwacha and so on.

There are problems in this since the rate of inflation may increase or decrease.
Further, the price of some goods or services may increase more rapidly - or more slowly -
than the overall inflation rate. Obviously, the longer the time period involved, the
more uncertain costings become. In a long-term project, costing should be reviewed
annually.

This problem is especially difficult to deal with when there is a long and uncertain
delay between preparing the costings and gaining approval to implement the project.

D. Costing policies

Each organization has policies concerning the way in which costings and budgets
should be prepared. This affects what "budget lines" are allowed (or required). For
example, some organizations will allow a budget line for "overheads", others will not;
some allow "contingencies", others do not. It is important, therefore, to find out in
advance what restrictions on budget lines exist for each organization with which you are
dealing.

Some organizations, especially nongovernmental organizations, have rules about what
kinds of expenditure they are prepared to pay for. For example, some organizations will
not pay for salaries of national employees. Others insist that salaries must be
identical with government salaries. Again, one must find out in advance what their rules
are.

Stages in costing

(1) Find out whether any rules concerning budget lines or funding exist in all the
organizations with which you may be working.

(2) Define the budget lines. (A "budget line" is a heading which describes in general
terms what the money is to be used for.) There may be major budget lines, such as
transport, salaries, etc., which are then subdivided. For example, salaries may be
divided into administrative staff salaries and field staff salaries.

(3) Calculate the costs. This is done by going back to the Project Schedule. For each
step decide what expenditure will be required under each of the budget lines. It is
usual to do a separate costing for each year of the project and to prepare a
summary, as below:

<table>
<thead>
<tr>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Budget line 1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>...</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>


Remember, it may be necessary to do separate summaries for kwacha and for dollars.

(4) Assign costs to funding agencies. The total costs in a cooperative budget may be borne by different agencies, so it is necessary to divide the costs according to the type and amount of contribution each agency is willing to make.

(5) Negotiate and gain approval. This final stage may take some time and require numerous adjustments to the original costings.
EXERCISE 1

What are the Local Health Problems?

The aim of this exercise is to stimulate you to think about the extent to which the "International Perspective on Urban Health" applies to your own urban area.

Process

This exercise is done in pairs, so start by selecting a colleague who works in the same urban area as yourself. In order for everyone to have at least one partner, it may be necessary to form some groups of three.

Individually look through the questionnaire overleaf and fill in your opinion as to the correct answer for your city. Do not worry if you have little definite information on which you can base your opinion at this stage; just give the best answer on the basis of what you happen to know now. As a last resort, make a guess!

In pairs (or threes), compare your answers. For each answer see whether you share each other's opinion. Then discuss the basis for your opinion: is it based on definitely established research data, or is it something much less reliable? Attempt to reach agreement on a combined set of responses.

The final stage is to join other pairs from the same city and reach a joint conclusion about the urban area where you work.
QUESTIONNAIRE

1. The urban population in my area is ________ thousand.

2. The rate of growth of the population is ____% per year.

3. The total population in my area in the year 2000 will be about _______ thousand.

4. The proportion of the population living in slum or squatter areas is ____%.

5. The proportion of the population living below the poverty line is ____%.

6. For each of the following factors, make a rating for how important the factor is in contributing to poor health or premature death in your city.

   0 = not important     to     5 = extremely important

(a) housing
(b) water supplies
(c) sanitation
(d) traffic congestion
(e) unemployment
(f) lack of food in the markets
(g) lack of education
(h) violence/crime
(i) air pollution
(j) industrial injuries
(k) avoidable unhealthy behaviour
(l) limited access to hospitals
(m) limited access to health centres
(n) land tenure laws
EXERCISE 2

Local Health Initiatives

The aim of this exercise is to help you focus on key issues during the presentations on approaches to Urban Health.

The process

During the presentations make your own notes on the projects/initiatives which are reported. Do this individually. Use the space below, plus additional sheets as necessary.

For each project:

1. How many people are likely to benefit?

2. What will the benefit be?

3. How much does the project cost?

4. How is the project financed?

5. What demands are placed on management/organizational skills?

6. Does the project appear to meet a high priority need?

7. Can the project be expanded and/or sustained?
EXERCISE 3
Choosing the Issues for Study

The aim of this exercise is to help you think through the issues that you will be studying during the field visits of the workshop. Then you will go on to make preliminary decisions about where the necessary data can be found and the general method for collecting the data.

Process

For this exercise work in pairs. During the exercise you will complete the questionnaire below which is related to Technical Paper No. 2 on Rapid Appraisal.

1. In the field do you wish to study:
   (a) policy
   (b) service provision
   (c) the environment-disease patterns, health status, health-related resources
   (d) the community

2. In which health-related sector do you wish to do your study:
   (a) housing
   (b) water/sanitation
   (c) specific health issues, e.g., immunization
   (d) other

3. What general question do you wish to answer?
   (a)
   (b)
   (c)
   (d)

4. If you knew the answer to your general question, how would this help you make better plans for the health of the community?

   At this stage, there will be a review to ensure that different pairs are tackling complementary issues.

   The end point of this exercise is the production of a series of issues chosen according to the preference of each pair of participants. These issues will then be considered during the field visit to identify to what extent the community regards these issues as important.
EXERCISE 4

Interviewing Techniques

The aim of this exercise is to give you some experience of both interviewing and of being interviewed.

Process

Work in pairs. It is probably better to work with someone whom you do not know very well. Decide whether you will be person A or person B - toss a coin if necessary.

1. Person A prepares a set of closed interview questions about diet and exercise as it may affect heart disease. Person B prepares a set of closed or open questions concerned with behaviour which might be associated with AIDS. Aim for interviews lasting less than 10 minutes.

2. Person A interviews B; than B interviews A.

3. Discuss the experience of the interviews.
   
   (i) Were true, full and accurate answers given? If not, why not?
   
   (ii) Did the closed questions prevent you giving your true opinion/answer?
   
   (iii) How did you respond to the sensitive nature of the questions relating to AIDS?
   
   (iv) How far can the responses to interview questions be regarded as the complete truth?

4. What specific questions do you wish to have answered? What sources/methods will be used (documents, key informants, observation, questionnaires - D, K, O or Q)?

   (a)  
   
   (b)  
   
   (c)  
   
   (d)  
   
   (e)  
   
   (f)
EXERCISE 5

Preparation for Field Visit

This exercise builds on Exercise 3, during which you decided what general questions you wished to answer during the first field visit. The aim of this exercise is to give you time to:

(1) coordinate the studies of the different pairs in the teams;
(2) prepare the data collection instruments;
(3) make logistic arrangements.

Stage 1 Form two teams of about nine members in each team.

Stage 2 Refer back to your conclusions in Exercise 3. Do you still want to consider these issues, or do you wish to change your mind? Each team should pay some attention to all of the four areas of:

- policy
- service provision
- environment
- community

At the end of this stage, you should have a series of issues which will be investigated by the team.

Stage 3 Decide which members of the team will investigate each issue. (Either one or two people must be assigned to each issue.)

Stage 4 As a complete team, agree on the general method of data collection for each issue. Also agree on the source of data.

Stage 5 Plan who will go where, when and how.

Stage 6 Work as individuals to prepare the data collection instruments.

Stage 7 Meet again as a team to review the prepared instruments.

In the time available, it will obviously not be possible to produce highly refined questionnaires, etc. This cannot be attempted. However, the point of the exercise is to give yourselves some structure to your field visit and allow you to gain experience of using data collection instruments - even though they cannot be perfect. One of the benefits will be that first-hand experience will be obtained of the consequences of using hurriedly-prepared instruments.
EXERCISE 6

Observation

The aim of this exercise is to make you familiar with the technique of observation.

Process

1. Choose an area in which you are interested in collecting further information. This could be how shared water supplies are used, or the drinking behaviour of young males, or use of health centres.

2. Draw up a checklist of what you would want to observe.

3. Include in your checklist at least one rating-scale item.
EXERCISE 7

Questionnaire Design

The aim of this exercise is to give a little experience in writing questionnaires. Concentrate especially on writing questions which are at an appropriate level of language and which avoid leading questions.

Process

For this exercise work in pairs. You are asked to prepare 5-10 questions on:

A. Usage of health facilities

OR

B. Nutrition

(If you wish to use a questionnaire in your field study, you may make a start on preparing this questionnaire if you wish.)

Then

1. Decide on the kind of information you would find useful in health planning.

2. Prepare a set of 5-10 questions to obtain at least part of this information. For the sake of this exercise, include at least some questions where the respondent has to choose between options. Also, include some questions which have a more open response.

There is only about 30 minutes available for this work, before your questionnaires will be reviewed in a group session.
EXERCISE 8

Preparing Field Visit Reports

Introduction

After completing the field visits, the experience of the different members of each team needs to be brought together in the form of a report. The aim of this exercise is to give you experience of coordinating information from different sources.

Stage 1 The teams formed in Exercise 7 meet again. Each team member presents the major results of his/her study. The emphasis should be on the overall findings - methods can be virtually ignored and detailed tables of data need not be presented. However, the data must be available in order to answer any questions which may be asked about the validity of the conclusions.

Stage 2 The team as a whole begin to assemble the overall team's findings.

Issues to consider are:

How does the result from person A compare with the result from person B? Are they consistent? Are they contradictory? Are they unrelated? Does the result from A cause what B found - or vice versa?

This stage should yield a pattern of relationship between at least some of the findings.

Stage 3 Identify themes for the report. The study starting by identifying a series of issues. These issues may be the themes of the report - or maybe the experience of the study will have given you insights which mean that new themes are more appropriate.

Stage 4 Prepare a written report. Pay most attention to the overall findings and themes; do not bother to present detailed data unless it is so surprising or so important that it must be presented in order to support a point. Ignore completely the processes of data collection. Do refer to any situations where data from different sources appears to be contradictory.

The report should be capable of being presented in about 15 minutes.

Stage 5 Select a person or persons to present the report. Prepare overhead projector transparencies, charts, etc., to support the report presentation.
EXERCISE 9

Criticisms of Current Plans and Provision for Health

The aim of this exercise is to focus the experience of the field visit by comparing the plans and provision of health services with the need for health-related services. The end-point will be a number of "problems" - that is, examples of needs which are not met, inappropriate allocations of resources (either too much or too little), procedures or regulations which inhibit the provision of health care, etc.

Stage 1  The workshop divides into three groups which each include representatives of both field visit teams. Both reports of the field visits are to be used by all three groups.

Stage 2  From the reports, try to identify the more important health needs (either on the basis of the observed health status of the community or on the basis of the community's perception of need).

Then consider the way in which the community responds to that need - is it ignored, is an attempt made to meet the need, or maybe the community does not regard this as a need.

Finally, the provision of services should be noted.

Stage 3  Look for consistencies and inconsistencies between the need, the community response and the provision.

In some instances, the aspects will be consistent or compatible. In others they will not. It is these latter which are the problems.

Stage 4  Make a list of the problems. At this stage do not put them in any particular order.

This exercise provides a systematic way of criticising plans for providing health care - or the actual provision of health care.
EXERCISE 10

Defining Targets or Objectives

The aim of this exercise is to define the targets which you feel would be most appropriate for improving the health of the urban population in the field area.

The targets are, in essence, a description of what the field area would be like if the problems identified in Exercise 10 were solved. For example, if a problem was "low immunization rate" then the target would be a "high immunization rate". However, it is not quite as simple as that. Some problems do not have a single solution - so it may take time to work out what the solutions would be. Also the targets should be capable of being tested - in other words, it should be possible in principle to tell whether the target has been achieved or not. Secondly, there should also be some kind of time scale - when will the target be achieved? And, thirdly, the target should be achievable.

Stage 1  Work in the field visit teams.
Stage 2  Starting from the priority problems, work out what the solution(s) would be.
Stage 3  Express the solution as a target in measurable terms, with a stated time scale.
Stage 4  Assess whether the targets are feasible - review the target(s) if necessary.
EXERCISE 11

Preparing Plans

The aim of this exercise is for you to work out a detailed plan for the field visit area, which describes how the targets identified in Exercise 11 could be achieved.

Stage 1  Divide your team into three pairs. Each pair will tackle one of the targets from Exercise 11.

Stage 2  Each pair considers the constraints and resources which are relevant to this target as per Technical Papers 11 and 12 and make a list.

Stage 3  Follow the procedure outlined in Technical Paper 13 to determine the steps needed in the achievement of the target and the timing of each step.

Stage 4  If time allows, prepare a costing. Probably time will be very limited for this stage, so, if necessary, make a rapid estimate of the total cost and prepare outline suggestions for where the resources and funds could come from.

Stage 5  Compare your plans with the plans prepared by other pairs for the same target.

Stage 6  Prepare a presentation of your plans which can be made to members of the community in the field area.
EXERCISE 12

Discussion of Plans with "The Community"

Plans for health can sometimes be imposed on communities without finding out whether the plans actually meet the needs of the community and without taking the advice of the community concerning the way in which the plans will be implemented. There are many examples of plans which have failed because of this lack of consultation. So, the purpose of this discussion is to make sure that the plans you have proposed are appropriate. In some ways, this stage is rather like a tailor going to a customer for a "trial fitting" to see whether the clothes he is making actually fit. The end-point of the exercise is a list of the alterations needed.

Stage 1  Present your plans to the community representatives. This presentation must be clear and reasonably brief. But, it must also be sufficiently detailed and specific for the community representatives to have something which they can express opinions about.

Stage 2  Encourage a response from the meeting. Much will depend on your attitude during this stage. It is easy to communicate that you are not really interested in "their" opinions - looking bored, making a negative response or no response to the ideas expressed, etc. The idea must be accepted - but not necessarily agreed to. Where the ideas are vague or possibly confused, you should explore and try to help the community representatives make their suggestions as clear and precise as possible.

Stage 3  Prepare a list of all the points made - not just those which you agree with.

Notes

1. Quite a lot of time may be taken up with the courtesies of such a meeting. Accept this.

2. Do try to see the plan from the community's point of view and to understand reasons for comments made.

3. Try to distinguish in your mind between those aspects where "the community knows best" and those where the community's lack of technical training may lead them to false conclusions.

4. You are asking the community to respond immediately to plans which you have spent some time preparing. Be tolerant if they misunderstand what you have said.

5. Ask yourself how well the community representatives actually do represent the whole of the community.

6. Where different members of the community express different points of view, do try to help them reach agreement between themselves.

7. Remember that you are asking the community to discuss hypothetical plans. These are not going to happen - at least, the workshop has no power to make them happen. So do not lead the community to expect something which cannot happen.

8. Do thank the community people for their time and their help.
EXERCISE 13

Revising Plans

This exercise is essentially a repeat of Exercises 11 and 12, with the difference that you are now taking into account the meeting to discuss the plans with the community.

Stage 1 Decide which of the community’s opinions you wish to act on. Make a list. It would be useful to make a list of the opinions which you intend to ignore - and give your reasons.

Stage 2 Work through the targets and schedules to accommodate the opinions which you are going to act on.

Stage 3 Prepare to present your revised plans to the workshop.
EXERCISE 14

Implications of What Has Been Learnt

During this workshop, each participant will have learnt various techniques for collecting data, consulting with communities and for planning health-related activities. But what do all these techniques add up to? - What are the implications for the future health activities in urban areas? What is the overall direction of future strategies? This exercise is intended to allow you to pause and consider where this workshop is leading you.

Procedure

1. Form three groups of six people. It does not matter very much which people form the three groups but they should, to some extent, represent a variety of places, professions and sectors.

2. Discuss each of the following questions and prepare agreed answers on the large sheets of paper:
   A. How much do health professionals and health planners know about the health of communities and about the community's needs for health-related services?
   B. How appropriate are the current patterns of expenditure and provision of services?
   C. How important is it to conduct surveys [even Rapid Appraisal types of survey] on a regular basis?
   D. What scope is there for altering patterns of expenditure or types of service?
   E. How appropriate were the procedures used during planning processes in the past?
   F. What are the most important steps in planning for future health-related projects, services or other activities?

3. Each group reports their answers in plenary session. Each answer is taken in turn and, where possible, agreement amongst the whole group on each question is recorded.
EXERCISE 15

Group Plans of Action

This is the final exercise of the workshop. It should serve as a practical way of linking the workshop with your future work, thereby emphasizing that the workshop was intended to lead to practical consequences.

The "Plan of Action" is the plan for each town/city which describes the actions that the team will take over the next six to 12 months. These actions are likely to be primarily concerned with collecting information and with making plans for future health projects. They may possibly include plans for the health projects themselves, but this is unlikely.

If this exercise is to have any value it must be related to what the teams seriously and realistically intend to do. The plans produced must represent some kind of commitment to actually undertake all the tasks and activities listed.

Procedure

1. Work in teams based on towns/cities, i.e. one team for each urban area.

2. Prepare a list of activities to be undertaken and complete the plan of action as per the example below.

<table>
<thead>
<tr>
<th>Title of Activity</th>
<th>Process</th>
<th>End product</th>
<th>Done by whom</th>
<th>Dates/Comments</th>
</tr>
</thead>
</table>

3. When completing the comments column, bear in mind particularly Technical Papers 11 and 12. Technical Paper 13 will help when filling in the first three columns.

4. Prepare to present the plan in plenary session towards the end of the afternoon.
SECTION SEVEN - EVALUATION

The Evaluation Process

The most important time to evaluate the workshop is, of course, several months after the workshop when one can find out how much the participants have altered their methods of working and have been able to introduce improved methods of planning or have been able to implement reorientation of health services. At the time of writing, this type of data is not available as insufficient time has elapsed.

An evaluation of the workshop did take place on the final day. Each participant was invited to make statements about aspects of the workshop which he/she felt were important. It was stressed that the statements need not reflect the participant's own point of view since each statement would be subsequently voted on by the whole group in order to determine what each person felt concerning that issue. The statements were then compiled as an overhead transparency. Where different people had similar statements, the statement was only recorded once. The wording of statements was clarified and each statement was discussed. Then, the participants voted in the absence of the workshop coordinator and local facilitator. The results of the voting are given below:

The Evaluation Data

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the sessions were very useful</td>
<td>14</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rapid Appraisal is a helpful technique</td>
<td>15</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The workshop was well designed</td>
<td>11</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The teamwork approach demonstrated in the seminar is effective in tackling health problems</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The use of group work was important</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I now appreciate the importance of time in planning</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The most important part was the planning</td>
<td>9</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>We were actively involved throughout the workshop</td>
<td>16</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>It was important to visit the community</td>
<td>15</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lecture on HUZA was less well presented</td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>I have learnt a lot from R.A. methodology</td>
<td>11</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Strongly agree</td>
<td>Agree</td>
<td>Not sure</td>
<td>Disagree</td>
<td>Strongly disagree</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------</td>
<td>-------</td>
<td>----------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>We really had to think for ourselves</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>The idea of &quot;Group Action Plans&quot; were useful</td>
<td>14</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>More time should be spent on costings</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>The facilities for the workshop were good</td>
<td>10</td>
<td>6</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>I will change the way I work a lot as a result of this workshop</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The duration of the workshop was too long</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>There should have been more lectures</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>The Technical Papers were very helpful</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>More time should have been given to the field visit</td>
<td>6</td>
<td>7</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>There should have been videos, etc., e.g. on interviewing</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>I will now adapt an integrated approach in dealing with P.H. matters*</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The Saturday session should stop at 13.00*</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Project proposals needed some more time</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>More time was needed in the community</td>
<td>4</td>
<td>3</td>
<td>-</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>It would help me if there were a follow-up visit</td>
<td>15</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Some did not vote.
ANNEX I

LIST OF PARTICIPANTS

Lusaka Urban District Council

Mr P. Saili, Assistant Director of Housing and Social Services
Mr J. Kamanga, Community Development Officer
Miss J. Chima, Lecturer, Post-Basic Nursing Department, University of Zambia

Ndola Urban District Council

Dr Victoria Munthali, Medical Officer of Health
Mr J. Msokva, Deputy Director of Housing and Social Services
Mrs P. Mubanga-Nkonde, Senior Nursing Officer

Kitwe District Council

Mr P. Chipasula, Senior Health Inspector/Occupational Hygienist
Mr G. Sinkamba, Senior Health Educator

Livingstone District Council

Mr W. F. Muwanei, Chief Health Inspector, Livingstone District
Mrs L. Tembo, Nursing Officer
Mr A. Chongo, Senior Housing Officer

Chingola District Council

Mr P. M. Sindazi, Health Educator (PHC)
Dr M. Simukonde, Chief Medical Officer, ZCCM

Mufulira District Council

Mrs J. Kakupa, Sister in Charge of Clinic
Mrs G. C. Mtine, Enrolled Midwife/enrolled Nurse
Mr E. K. Mulenga, Chief Health Inspector

WHO/Support staff

Mr P. Abbat (Consultant)
Mr D. Chanda (Resource Person)
Mr H. Kabinda (Visiting Speaker)
Dr K. Kamanga (Temporary Adviser)
Mr Mukata (Resource Person)
Mrs C. Riley (WHO headquarters, Geneva)
Dr I. Tabibzadeh (WHO headquarters, Geneva)
Mr J. A. Zulu (Temporary Adviser)