LISTENING TO
THE SILENT PATIENT

UGANDA’S JOURNEY TOWARDS INSTITUTIONALIZING
INCLUSIVE PLANT HEALTH SERVICES

Edited by Remco Mur, Frances Williams, Solveig Danielsen,
Geneviève Audet-Bélanger and Joseph Mulema
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PART I

The evolution of plant clinics in Uganda
Plant clinic adaptations

By Geneviève Audet-Bélanger, Remco Mur and Joseph Mulema
The ways in which plant clinics operate, are managed and integrated into the wider plant health system, and become part of policies, procedures and routine practices depend on many factors, including the agro-ecological, policy, institutional and socio-economic environment. These factors differ from county to county, district to district and plant clinic to plant clinic. The process of establishing performing and effective plant clinic services requires local adaptation, e.g. looking for creative ways to make the best of scarce resources to reach as many people as possible and create synergies with other activities. New ways of operating plant clinics have been tried in the attempt to reach more farmers, reduce the plant doctor workload and improve the quality of the services to clients.

Several examples of local adaptation are described in Part II of this working paper, including using plant nurses and change agents to enhance the reach of plant clinics and compensate for staff scarcity, partnering with farmers’ associations to deliver a daily plant clinic service, and using a mobile scheme to cover a larger area. Another adaptation (in Hoima) is delivering advice to groups rather than individuals to minimize waiting time when the turnout is high. A new idea from Hoima, which remains to be implemented, is to establish animal clinics in connection with the plant clinics and use the NAADS livestock agricultural advisory service providers (AASPs) as service providers. In addition, communication, mass media and ICT are playing an increasingly important role in disseminating information. Knowledge and experience sharing among plant doctors and other stakeholders is essential for plant clinics to evolve and adapt to their clients’ needs.

“I look also at using the experience of the plant health clinics to bring up mobile livestock clinics. Actually we are thinking about conducting parallel sessions as this one is plant health clinic, our livestock officers could around the same place conduct a livestock clinic. Farmers also have had challenges of getting these services. That would address the one health approach.”

Charles Kajura – District Production and Marketing Officer, Hoima

In some districts, clinic sessions are held on field days alongside the NAADS activities to enhance visibility and create awareness among the policy and decision makers. There are also examples of plant nurses from Buikwe mobilizing the community for plant clinic activities through community functions such as funeral rites, wedding ceremonies, church meetings and other informal community gatherings. Some communities in Buikwe use home-grown ways of creating
awareness about community events, including plant clinics. For example, in Goli village, Najja sub-county, a mobilization drum, locally called ‘Sagala Agalamidde’, is kept by the chairman and used to alert the community about new initiatives. In this chapter, we discuss some of the adaptations.

An overview of some of the plant clinic adaptations

See the nurse first…

Plant clinic operations are often the responsibility of a single plant doctor. But what if five farmers suddenly show up within 15 minutes, all equally eager to receive attention? The plant doctor wants to satisfy the needs of all. Because the plant doctor cannot attend to everyone all at once, some clinics have started to work with plant nurses – as in human health clinics.

Plant nurses serve as an interface between the farmers and the plant doctors and are usually able to answer simple queries from farmers. Additionally, they register the farmers’ attendance, prepare the samples brought for diagnosis, and participate in the mobilization activities of the clinic. The nurses do not necessarily receive specific training on plant health or plant clinic operation. They receive on-the-job training by attending plant clinic sessions. Nurses are usually CBFs, NAADS service providers or lead farmers. They may receive a small allowance for food and transport.

Always when the farmers come with problems, there is a diagnosis. We have to get the foundation, the history of the problem of the farmers, find where they’ve got the plant, the surrounding crops, the spread of the disease, what have they been doing to control the disease, what they’re doing on the neighbouring farms, then we see the basis. Then after we diagnose the problem, then we advise the farmers.

Aijuka Violet – plant nurse
10 Listening to the silent patient

See the plant nurse first
Change agents – a service from within

In other districts, change agents serve as the interface between farmers and the plant clinics. The change agents are volunteers – mostly lead farmers who are well-respected in the community. As they acquire knowledge by attending the plant clinic, they are sometimes called upon to advise in simple cases. In the villages, they disseminate the information they have acquired at the clinic to other farmers. And farmers sometimes go directly to the change agents before travelling to the plant clinic. They are a trusted source of information at village level and are able to refer farmers to the right service if they are not able to help the farmer further. (Film114) As volunteers, the change agents are not paid for their contribution to the plant clinics and mobilization duties. Acquiring knowledge, exposure and visibility are the main incentives to participate in these activities.

A careful selection of change agents is necessary to ensure maximum inclusion and reach to farmers. Criteria for selection of change agents include having a good network and being well-connected – not only to the elite but also to women and to more vulnerable groups. Change agents can be part of or connected to a farmer group, but this also represents a risk of exclusion of non-members. Hence, change agents need to be well-respected and trusted by the different groups in the community to provide inclusive services in the community where they operate.

“Since we are not on the ground all the time, we have to get people that are in touch with farmers all the time, providing technical backstopping. We try to find them, find those who can go and assist when we are not available. The problems are always there. Farmers can’t wait for us to be available and bring their problems to us. With the change agents being always present in the area, they can always contact them. Then, if they can’t manage to address their problem, then they try to reach us and we give them feedback.”

Asaba Joseph Mercy – Plant doctor, Hoima
Services on the road… mobile plant clinics

With the hosts and the locations of clinics changing, strategies to reach farmers also change. In broad terms there are two plant clinic delivery models: fixed and mobile. The fixed clinics run according to a set schedule, a regular interval, and have a set location and time. They operate mostly at markets or trading centres from 9.00 or 10.00 am to 1.00 or 2.00 pm, so that farmers are less likely to be in the field.

Fixed clinics are sometimes announced with a road sign to indicate their location. The big advantage of the fixed clinics is their regularity. But the regularity of the clinics can be compromised when plant doctors have to juggle other priorities.

Infrequency and lack of punctuality in clinic services affect the farmers’ confidence in clinics. If farmers travel to a plant clinic and find it closed when it should have been operating it reduces their trust and the clinic’s credibility. Farmers will be less likely to try and visit the clinic again.

<table>
<thead>
<tr>
<th>Region</th>
<th>Fixed</th>
<th>Mobile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>Eastern</td>
<td>44</td>
<td>1</td>
</tr>
<tr>
<td>Northern</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Western</td>
<td>42</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>126</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

Table 10
Mobile plant clinics – as the name says – do not operate in fixed locations, but travel to various locations in a district where there are no fixed clinics. They operate less frequently in any one area but cover a wider territory and have the potential to reach more farmers (Table 10). The lower location-specific frequency may make it more difficult for plant clinics to respond to farmers’ needs as required: a pest does not wait until the next clinic session to damage the crop. On the other hand, more farmers in the different locations may be able to access timely advice. That is the trade-off: outreach versus frequency.

Self Help Africa was the initiator of mobile clinics. Initially starting with fixed clinics in Kayunga district (Central Uganda), it realized it was not reaching its ‘beneficiary farmers’, i.e. those farmers, men and women, individually or as a group, that participate in other Self Help Africa projects. Located in markets, clinics were too far away for producers to make a visit specifically to submit a sample. After consultation with local leaders, the idea of the mobile plant clinic was born.

"Kayunga district is unique because when we tried to fix the clinics the attendance was not very good. So when we went on a mobile basis we pitch a camp so farmers can have a service, so we keep on rotating.”

Misaki Okotel – Self Help Africa

“For instance a farmer group that has a certain plant health issue that all their farmers are facing, may contact Self Help Africa and request that a plant clinic be held for them. The plant clinic will hold a general meeting on the identified problem, providing advice on management techniques, and different technologies if appropriate. After this general briefing the plant doctors will then hold a regular clinic session to which the farmers will bring their plant samples for diagnosis as usual. This combination of mass extension and clinic operations has the advantage of reaching larger numbers of farmers, but does move away from the standard idea of a plant clinic as it is not held at the same place on a regular basis.”

(CABI, 2014, p.9)

Mobile plant clinics have the potential to be more inclusive as they are closer to the farmers. Women in particular face time (and other) constraints that prohibit them from travelling to a market place far from their village. By having mobile clinics operating closer to their village, women are expected to have easier access to them.
However, mobile clinics can also be exclusive. For example, the Self Help Africa clinics are still perceived as being for ‘beneficiary farmers exclusively’ and not for the wider community. Clear communication and engaging with the right actors are essential in promoting inclusion.

**Individual, group approaches and clustering**

Information delivery can differ from one clinic to another and from one situation to another. When circumstances allow, farmers’ queries can be answered individually. However, when too many farmers arrive at the same time, the plant doctors have found alternative ways of answering their queries. In some cases, when many farmers come with similar problems or the same crops, they can be attended to in small groups – clustered by crops and/or pest/disease. In other cases, queries can be answered in plenary sessions and farmers attending have the opportunity to learn about other crops and plant health issues beyond those that they brought themselves.

_“The information here is specific, in the sense that, first of all, before the day the clinic is supposed to operate, we are informed about it. On the loudspeakers they inform the villagers about it, and I can organize. We come with problems to get a specific answer. The other information does not concern me directly, but it is still information.”_  
Kato John Ssemawere Tremmsa Nkonkonjeru – farmer
ICT and mass media: new strategies

The use of information gathered from the plant clinics for a wider audience of farmers is important. RIC-NET has been working on a number of strategies to share meaningful information with a wider audience. They have been using local information points: these are group managed locations at village level where information is disseminated through movies, brochures and leaflets. The information points are usually located at community centres or farmer group venues. The information on and from the plant clinic can be shared at those points. RIC-NET also uses SMS text messages to disseminate extension messages to farmers. RIC-NET and Self Help Africa also sponsor talk shows on the radio where outcomes of the plant clinic sessions are shared. During the talk shows farmers can call in to inquire about certain diseases. To make sure plant doctors can access information when needed, RIC-NET has started to use smartphones and to develop an online electronic library where useful resources for plant doctors are aggregated.

“At a moment last year we were able to attend to 837 farmers through the plant clinics and we run every week five plant clinics. Our plant doctors are also supported by RIC-NET by smart phones so they could access content online. RIC-NET developed an electronic library where the plant doctors can link to many resources. We’re also connecting plant clinics to information centres that we have in the region and these are owned by the farmers themselves. So they run all the extension from the markets and from farmer-to-farmer information sharing.”

Murugahara John Silko – Executive Director RIC-NET

Holistic services to improve agricultural livelihoods

Most plant doctors are trained extension agents – they are knowledgeable on more than just plant health. Although the Plantwise theory of change assumes that plant clinics address any crop and any problem and plant doctor training emphasizes the importance of distinguishing between abiotic and biotic problems during diagnosis, there tends to be a focus on pests and diseases at most clinics. Some have started to provide more holistic services to their clients during plant clinic sessions, including advice on good agricultural practices, soil advice and testing, as well as advice on
animal health. This may result in more costly and manpower intensive clinics, but could also be more responsive to clients’ needs and foster cross-pollination between different extension services. But eventually, it could be more efficient, as experiences from Hoima suggest:

Plant clinics are viewed as a very effective extension delivery mechanism by extension workers in Hoima. During plant clinic sessions, plant doctors learn a lot about current pest problems and outbreaks in the area, as well as other prevailing problems caused by e.g. poor soil health. Realizing the value of the information they are gathering at the plant clinic, the plant doctors use it to develop extension messages and complementary training sessions as part of their general extension work. They develop tailored training sessions for farmer groups or women’s groups to help the farmers cope with the problems they are facing. For the extension workers, the plant clinics provide a huge bonus in that the problems farmers are facing in the area are quickly brought to their attention. Plant doctors consider the plant clinics to be highly complementary to other extension methods.

How local adaptation improves service delivery

Local adaptation is a prerequisite for plant clinics to be sustainable. In the end, adaptations are a response to local challenges and are an attempt to improve service delivery to farmers. Improved service delivery includes outreach (number of farmers), exposure (diversity of information), inclusion, proximity to the service, relevancy of the information and quality of the advice provided. It also means the integration of the services into the wider agricultural extension context. Not all adaptations have the same potential to influence the different components of improved service delivery positively. At this stage, a number of adaptations have emerged, but there is no evidence of impact yet. (Table 11)
Local adaptations in plant clinics.

<table>
<thead>
<tr>
<th>Adaptation</th>
<th>Reach</th>
<th>Proximity</th>
<th>Inclusion</th>
<th>Quality</th>
<th>Relevance</th>
<th>Exposure</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Change agents</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td></td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Mobile clinic</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Farmer groups and clusters</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>ICT and mass media</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Holistic clinics</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td>++</td>
<td></td>
<td>++</td>
</tr>
<tr>
<td>Rallies</td>
<td>++</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

+ adaptations tackle the problems;
++ adaptations have a strong influence on the problems.

Table 11

Most of the adaptations have addressed reach. The engagement of plant nurses and change agents are good ways to mobilize farmers at community level and increase awareness of the services offered – while also providing closer proximity to the farmers. Mobile clinics and use of ICT also address reach and proximity of the services to the clients. Not all adaptations have the capacity to foster inclusion, however. To date little adaptation has been recorded in relation to gender – but there is potential. Mobile plant clinics, for example: by being closer to the clients make it easier, presumably, for women to attend in spite of their busy schedules. In addition, ICT allows information messages to be specifically targeted at women and excluded groups. Change agents, when well-selected, have the same potential.

Reach and inclusion are essential, but the relevance and the quality of the advice are also key to the system. Advice invariably needs to be adapted to the context and to the user. The local adaptations made by plant clinics mostly address the reach of advice. But potentially they can also contribute to the relevance and quality of the advice and the system’s responsiveness to farmers’ needs. The plant nurses, for example, are now helping the plant doctor to process the clients, leaving more time to the doctor for diagnosis. Exposure relates specifically to the diversity of
information to which clients, and the wider community, are exposed. Groups and clusters allow farmers to sit in and hear about various problems and crops, hence improving their general agricultural knowledge. ICT and mass media can be used in a similar way to reach more users and non-users of plant clinics.

Finally, integration of plant clinic services into the wider plant health (services) systems is about sharing and absorbing the knowledge generated and information gathered within and outside the boundaries of the plant clinics to foster a more responsive plant health system, for example by including the outputs of plant clinics in wider extension messages and services. It also requires building effective linkages with other service providers, such as research and input suppliers. ICT and mass media are useful tools for this, but the plant doctor cluster meetings, and rallies, even if they are not considered adaptations, also have the potential to help foster a more responsive system. They provide the necessary opportunity for plant doctors to interact and discuss practices and adaptations. Many plant doctors have indicated that they are using the information and knowledge generated at the plant clinics in their other extension activities.

References