

COMMUNITY HEALTH NEEDS, COMMUNITY PARTICIPATION, AND EVALUATION RESEARCH

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ABSTRACT

The values which underlie a social program, and the ways in which they are realized in the program itself, are often left unspecified by the program planners. Two procedures to give practical effect to social values in a community health project are discussed in this paper: careful and systematic assessment of need; and community participation and involvement.

INTRODUCTION

In their pivotal contribution to evaluation theory, Shadish, Cook and Leviton (1991) identified five components essential to a good theory of evaluation. One of these was a theory of value, which deals with the representation of values in evaluation, and how the worth of social programs is determined. In their own formulation, "Social programs, and the policies that spawn and justify them, aim to improve the welfare of individuals, organizations, and society" (p. 19). Thus one needs to ask: What do we mean by the "improvement of social welfare"? Obviously, the criteria to provide answers to this question are not clear, since a pluralism of values determine possible criteria.

In many cases, the values underlying a particular program, or the notions of "the public good" it entails, are not explicated. When we were approached to evaluate one element of a local community health project, it

became clear that the criteria for what counted as "the public good" were not made explicit in the design and implementation of the project. Obviously, this did not mean that these were absent; they simply were more or less implicit in the deliberations about the project. In the part of the evaluation reported here, the procedures followed by the researchers were examined to provide clues as to the values which underlie the project. In other words, what attempts were made to ensure that the objectives of the program were socially worthy? This is intended as the first step in a general evaluation of the community health workers project, and provides an opportunity to examine the valuing component of program evaluation theory in a practical, community-based setting.

Broadly speaking, there were two ways in which researchers and service deliverers gave practical expression to this component of evaluation. Firstly, the project has been driven by a careful identification and

assessment of need in the community. Needs are value judgements: a judgement that services available to a community are inadequate, and that specific actions will correct the inadequacy (McKillip, 1987). Need analysis, however, also is an aid to decision making. The second strategy employed in the project therefore was to involve the community closely in the decisions taken about intervening in the problems identified. The community itself became increasingly powerful participants in the project, in terms of prioritizing the identified needs, but also as researchers and service deliverers. Although needs assessment and community participation are widely acknowledged as important elements in social programs and their evaluation (for example Walt, 1990), it is their translation into practice which often provides most difficulty. This project provides valuable examples of such a practical engagement.

BACKGROUND TO THE PROJECT

Public health, health policy, and new models of health care delivery are increasingly being prioritized in the South African health sector. Unfortunately, although selected health services statistics are collected routinely, variations in accuracy and completeness place severe limitations on their usefulness. If the dubious reliability of census information, especially with respect to rural and urban black communities, is also taken into account, it is clear that information about the most basic health is lacking in South Africa (Hoffman, Yach, Katzenellenbogen, Pick & Klopper, 1988). In 1986 the Centre for Epidemiological Research in Southern Africa of the Medical Research Council and the Department of Community Health at the University of Cape Town launched the Mamre Community Health Project through an awareness of the importance of health status information in the debate about health policy and models of health care.

The village of Mamre was selected because it is a well-established community with strong traditions; it is less than an hour's drive from Cape Town; and residents live in about 900 houses in a well-defined and circumscribed area (Hoffman et al., 1988). In terms of a need analysis, this made the description of the target population and service environment easier. The relatively small area and stability of the community furthermore gave the project a reasonable chance to be successfully implemented.

The village is situated on the Cape West Coast, approx. 40 miles from Cape Town, with a population of approx. 6000 people. It was one of the first Moravian mission stations in South Africa, but at present it has a secular character. It is undergoing a rural-urban transition, manifested for example by recent installation of

modern infrastructural services, such as new sewage works and electrification of the village.

The Mamre community is disadvantaged in a number of ways: under apartheid laws, inhabitants were classified as "coloured" (mixed race) and were therefore disenfranchised; it is a largely working-class community with a high rate of unemployment; while it does not share in urban resources, it is close enough to the city to be faced with all the problems of urbanisation, e.g. violent death; and transport costs to Cape Town are high, making commuting and access to specialized health services prohibitively expensive.

THE MAMRE COMMUNITY HEALTH PROJECT

The Mamre Community Health Project (MCHP) was initiated primarily as a research initiative by the research bodies mentioned above, but a substantial service component was included later as well.

Assessing Health Status and Identifying Need

In terms of an assessment of need, the initial phase of the project was to assess the health status of the population. A community-wide household health survey on the entire population was undertaken, using local residents as interviewers. In addition, routinely collected information pertaining to health (births, deaths and other notification records) was also collated.

Health problems identified by this baseline survey were:

- chronic diseases, such as tuberculosis, hypertension and asthma;
- acute diseases, especially respiratory infections amongst children;
- chronic care and rehabilitation of elderly and disabled people;
- psychological distress;
- socio-economic problems, including unemployment, inadequate housing and poor environmental conditions;
- trauma, due to accidents and violence; and
- smoking, alcohol and other substances abuse.

A number of large and small health surveys have been completed since the 1986 baseline study to up-date the information. It is intended that the planning of the future health service in the area should continue to be based on the identified needs of the community, and on evaluations of the services provided.

Thus the health status survey acted to identify problems in this regard in the Mamre community. This approach to defining "needs" we believe is in line with Scriven and Roth's definition (1990), that need refers to the gap between nothing and what is required to avoid

malfunction. That is, without the “need” being met, people would be in an unsatisfactory state; with the “need” met, they would achieve a satisfactory state, but would not exceed it. A project or an element of a project would be “good” if it meets an important need. This definition, and the practical interpretation given to it in this project, provide at least a minimal criterion of what can be considered as “improving social welfare”. In Shadish, Cook and Leviton’s terms, it is an example of descriptive valuing (1991, see p. 51).

The health needs in the community highlighted by the survey prompted the development of interventions which addressed some of these needs. Indeed, it was the concern with improving the health of the people of Mamre, and their needs, which contributed to expanding the project from its initial research orientation to include a substantial service component. These interventions included a nutrition intervention, which focused on a gardening project and which initiated the establishment of a school feeding scheme; a number of mental health interventions, run by psychologists with clinical interest who joined the project in 1989; and a hypertension intervention program, started in 1990. In the latter, inhabitants attend a blood pressure station run by a health worker from the community. People are screened for hypertension, and those with established hypertension are monitored.

The most recent intervention was a Community Health Worker (CHW) project, introduced in 1992. Within a community based primary care model of delivering health services, such as the MCHP, a system of community health workers is often included, especially in developing countries. In this system minimally trained health workers are used to deliver services in close proximity to the end users. The CHW project, introduced as part of the MCHP, provides an opportunity to discuss in more detail the extent of community participation in the project.

Community Participation

Although the MCHP was initiated by the institutions mentioned above, attempts were made to ensure that control of the project should not rest with them. Firstly, access into the community was negotiated with the major groupings in Mamre—the church, the Village Management Board and the school. Following their approval, a series of public meetings were called, attempting to get broader support of Mamre residents for the project. Approval to start the project was obtained via this process in 1986. A project steering committee was elected by the meeting, comprising mainly health personnel and teachers. Since these public meetings were not well attended, it was clear that the mandate for the project was given by a relatively small number of inhabitants. A further factor of concern was the composition of the steering committee, which clearly

was not representative of the community as a whole. Nevertheless, given the practical difficulties in trying to involve a whole community in a project such as this, the project got under way on this basis. The steering committee functioned as a reference group for research efforts, advising on research direction, logistics and questionnaire design (Katzenellenbogen, Pick, Hoffman & Weir, 1988).

Obtaining permission to conduct the research, and approval for the subsequent interventions, clearly was a political task, requiring negotiation and consultation. To increase community involvement in the initial stages of the project, it was decided to use members of the community to conduct the first major part of the study, the health status survey. In addition, the research team committed themselves to make all results available and accessible to all inhabitants of the village. Thus report-back events were organized, posters of important results were exhibited at important social functions, an easily readable booklet of results were hand-delivered to every household, and a slide-show was produced to present at house and club meetings.

Increasing community participation and control remained a serious concern. In 1988, for example, a research assistant/liaison officer, a resident of Mamre, was appointed, who ensured that the project had a physical presence in Mamre and liaised with health services and the community at large. This appointment enabled the project to respond to issues more immediately and appropriately, although community participation was still not “institutionalized”.

The possibility of a CHW component of the MCHP was mooted as early as 1989, and its development provided the chance to place community involvement on a firm, structured footing. At first a CHW Working Group was formed, comprising mostly academics and researchers of the University of Cape Town and the Medical Research Council, as well as the liaison officer in Mamre. (Again the initiative for considering this project came from the researchers, but steps were taken immediately to consult the Mamre community regarding the possibility and acceptability of the CHW project.)

In April 1990 a meeting with representatives of existing organizations, such as the church, the Village Management Board, the health clinic, sports club, the Ratepayers Association, and Child Welfare Association was called, to discuss health problems in Mamre. A list of perceived problems was generated by those attending the meeting and included:

- alcohol and other substance abuse;
- unemployment among and lack of recreational facilities for the youth;
- lack of home care for aged and handicapped individuals;

- lack of employment opportunities in general;
- tuberculosis;
- teenage pregnancies;
- high blood pressure;
- no after-care for stroke patients;
- no follow-up facilities for tuberculosis and high blood pressure patients;
- smoking; and
- no rehabilitation facilities, such as physiotherapy and occupational therapy.

The idea of a CHW project to address the most urgent of the identified problems was introduced by the research team, and received unanimous support from the meeting.

Nevertheless, representatives were still asked to consult with their respective organizations, and they reported back to a meeting in May 1990. At this meeting, twelve organizations came out in support of pursuing the development of a CHW project; none was against it; while five did not discuss it. On this basis, it was decided that there was enough support to continue.

The CHW working group was charged with the responsibility of developing a proposal for a CHW intervention in Mamre, based on directives given and discussions which had occurred at the consultative meetings mentioned above. The working group, guided by the priorities perceived by the community as well as by the research results, targeted two fairly unconventional groups for intervention by CHWs: the youth and others at risk for substance abuse on the one hand (focus on promoting a healthy lifestyle), and chronically ill and disabled people on the other (focus on direct "care" work). Thus this program has deviated from the more typical maternal and child health focus of other CHW programs.

The proposal drawn up gave details of the type of work the CHWs would do, the accountability structure of the staff, supervisors, and community committee as well as an estimated budget. This proposal was taken to a follow up meeting with community organization representatives for final approval before fund raising attempts were launched. Fund raising thus started only after the process of community consultation described above.

At the same meeting where this prioritizing of needs took place, it was recommended that the community health workers themselves should come from the community. It was argued that they knew and understood the problems of people in Mamre, and would be acceptable almost immediately. This was in line with the policy of the project from its inception, as numerous references to the involvement of local people demonstrate. In addition, emphasis was placed on the provision of adequate training to these individuals.

Importantly, these consultation meetings were then formalized into the Mamre Health Forum, comprising representatives of all organizations and clubs. Since its formation, it meets on a quarterly basis, providing direct consultation with and feedback to the "organized" sector of the community, and is therefore a formal, organizational recognition of the importance of community consultation and participation.

Since its inception this forum remained the overall arbiter of not only the acceptability of the CHW program, but also its design and organizational structure. Any plans for future research or intervention can only be finalized after consultation with the community in the Health Forum. This is not a simple and orderly process, but one which requires complex decision making, involving the broadest range of stakeholders possible. Also, organizational structures and procedures very seldom work the way they are intended to. After about six months it became clear that the organizational structure of the project was not working well, and in fact was jeopardizing the principle of community participation and control. The entire MCHP and CHW projects therefore were restructured.

Originally the intention was for the co-ordinating committee to run the CHW project parallel to the "parent" project, the MCHP. After six months, however, it became clear that this parallel structure created logistical problems. The lines of accountability were different for the CHW and MCH Projects, and too many aspects were still being controlled by "outsiders". After consultation with the co-ordinating committee, staff, and other stakeholders in the project, the MCP and the CHW projects were restructured into a single organization. The staff of the CHW program now form an integral part of the health team of the MCHP, and share accommodation with other staff and students associated with the MCHP.

These developments underscored the importance of flexible planning in implementing interventions in which communities maintain a substantial role. It also was an important point of transition in the life cycle of the project, in which community control of it was increased.

Community participation and control over the project have been extended, by placing the financial control of some components of the project directly in the hands of the community committee. In fact, the first phase of funding from the project's primary funder, the Independent Development Trust, has come to an end. This, taken together with the fact that the project has been in operation now for the past two years, made it ready to be evaluated. In this evaluation the principles of need assessment and community participation outlined here will continue to influence the research. That is, program and staff development will be an important focus, and will involve all staff of the project in an ongoing process of evaluation.

CONCLUSION

In this paper we focussed on two important aspects of introducing community health services in a disenfranchised community: how it is based on identified need, and how it involves the community. Both of these are important elements in attempting to address questions about improving social welfare through this kind of project, and in empowering disadvantaged communities. The steps taken to ensure this, described above, provide very practical guidelines for how to do this successfully in a small, circumscribed community.

When issues of "social welfare" and "the public good" are considered, it should be kept in mind that development of the project takes place against the background of changes in the South African health sector and in the country more broadly. The MCHP is one of many non-governmental organizations which sprung into existence in the 1980s to avoid working within the tainted state health system. Nevertheless, there always was a realization of the need for collaboration between the project and the health services, both public and private. With health policy and services currently in transition, the possibility that a small-scale project such as this one may be able to make a considerable contribution to the national debate is very real. The new government's increasing commitment nationally to primary health care in general, and community health workers in particular, makes it all the more urgent for the project to provide information for planning. This would require the establishment of a new partnership with the state health services, something the project is actively working on.

Thus it is not unrealistic to aim to develop Mamre as a demonstration site for health personnel and for program development, as it offers a unique opportunity to demonstrate possible effective service delivery at a local level. This increases the importance of considering community needs and community participation as part of an overall evaluation of the project, especially at a time when health policies at a national level are still being formulated. Moving from a local to a national level of involvement of course introduces its own set of difficulties, as summarized by Heller (1990). This produces a new challenge for the researchers and for the community, to strengthen their project's contribution to the national debate.

It is still an open question whether the community as a whole has accepted the research and interventions. This will be one of the questions addressed in the evaluation. For the time being, indications are encouraging.

For example, one way to judge the acceptance by the community is in attitude towards ongoing research. Response rates to surveys remains high, ranging from 78 to 83%, despite the fact that the community has been subjected to a lot of research in the past six years. There is evidence that increasingly the community is able to participate in research, understand the research results and use them to advocate changes (Katzenellenbogen, Swartz & Hoffman, in press). Indeed, these researchers report that respondents have commented that they see participation in the research process enabling them to make a personal contribution to the community.

The health forums initiated by the MCHP created the opportunity for the Mamre community to co-operate in a project which acted as a unifying force. Part of its strength was its local focus, with "increased local participation and citizen-researcher collaboration" (Heller, 1990, p. 160). Initiating the process of consultation, and setting in motion procedures to make research and intervention accountable to the community, were important processes for this disenfranchised and marginalized community, and contributed in a substantial way to the community's increasing sense of determining their own development (Katzenellenbogen, Swartz & Hoffman, 1996).

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