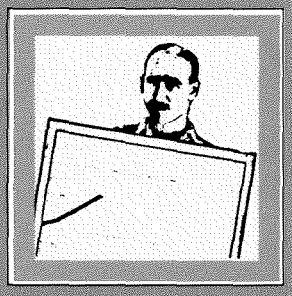
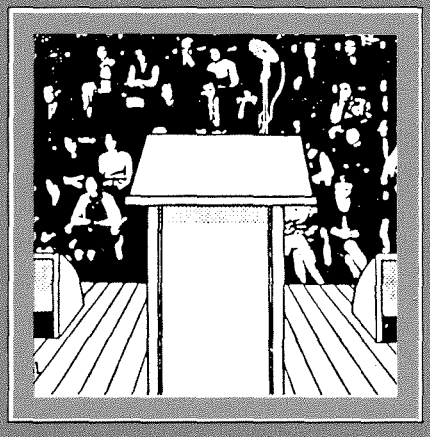
TOOL AND METHOD

A focus on the experience gained in the use of various approaches to planning and evaluation in community development work in health.



There is a growing demand for better tools for planning and evaluation and a growing willingness to explore the area.



The power of the party with the purse strings is more than the power of the often fragile and disparate members of committees of management.

Community development work enables people to organise together around their own needs and concerns in order that they become more in control of the processes which affect their lives

DHC's have demonstrated how the disciplines of strategy planning can assist with keeping in view a clear and implementable agenda of change.

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Community Development
in Health

Tools and Methods for Planning, Evaluation and Accountability

A scan of practice

Prepared by the Community Development in Health Project.
Project Worker - Wendy Chew

November 1988

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CONTENTS

1. INTRODUCTION

The Community Development in Health Project was conceived and funded with a view to identifying and/or developing resources which would be of assistance to health workers and agencies seeking to use a community development approach in their work. This paper has been prepared as one unit of the CDIH Resources Collection.

The focus of this paper is on tools and methods or, more accurately, on the experience which has been gained in the use of various approaches to planning and evaluation in community development work in health or which have been used to mediate accountability relations.

We arc not suggesting that planning and evaluation are merely technical tasks that can be undertaken if you simply know how. Tools and methods in planning and evaluation are not a substitute for knowing where you are trying to go and why.

This paper should be read in conjunction with our more theoretical paper about the interrelatedness of planning, evaluation and research.Cl) In that paper we also argue the importance of approaching these practices with a clear understanding of the accountability context.

The tools and methods included in this collection vary across several different dimensions. Worth noting is the way in which they vary in relation to the organisational scale at which they operate and in their underlying conception of accountability.

The tools and methods presented range from local on-the-ground techniques such as systematic listening (Section 3), project planning (Section 2) and strategy planning (Section 4); through to programs which operate at the state level such as the QUAC Project (Section 7) and the Health Service Agreements Program (Section 8) to a national level project, CHASP (the Community llealth Accreditation and Standards Program, see Section 6 below).

More fundamental differences between the various tools and methods presented arise from the underlying assumptions about control and accountability which they express. Is accountability understood in terms of a hierarchical reporting relationship ('upwards') or is it understood as a network function in which health workers, agency managers and health planners arc all accountable, each within a network of different relationships and accountable for different aspects of their work within each relationship?

The QUAC Project (Quality Utilisation Accountability and Cost, see Section 7) is based on a concept of performance reporting up a hierarchy of control at the base of which is the project worker, then the committee of management, the regional office of the Health Department and at the top, the minister. The reports which are submitted at each level are taken from the same basic set of information about what the worker has been doing, albeit abstracted and aggregated into summary formats at each level of the hierarchy.

The Health Service Agreements Program (Section 8) is based on the same hierarchical reporting concept to which is added a clearer sense of control. At each level the performance indicators become control variables; service objectives to be negotiated within broad policy parameters determined from above.

PATCH (the Planned Approach to Community Health, see Section 5) illustrates the same focus on outcomes, measurable indicators of achievement.

In contrast, the assumptions which underlie CHASP (Section 6) would be better described in terms of a network of different accountabilities. CHASP provides a set of standards (general statements about how things should operate) and a set of indicators designed to assist a group of visitors (peer reviewers) to make reasonably reliable judgments about bow well things are operating. The reviewers then prepare a report. The information which is generated is new. It reflects the judgements of the reviewers about how well the agency is doing what it says it is supposed to do. The reviewers will have regard to any performance measures about services and programs which are available, but their report will encompass issues of process as well as issues of outcome and will locate quantitative measures within their proper context.

It should be noted that among the standards which are included in CHASP are standards about the planning and evaluation process within the centre, about the accountability of staff to the committee of management and of the committee of management to the local community.

The tools for project planning and evaluation (Section 2) and the strategy plan concept (Section 3) also assume a network of accountability loops rather than hierarchically reported performance measures.

The purpose of presenting these different tools and methods together is to provide a practical framework for a continuing discussion about how to approach planning, evaluation, research and accountability in applying a community development approach to health issues. They arc not models of excellence to be reproduced slavishly but represent practical attempts to address some commonly faced problems. It should be recognised that many of the problems which they seek to address express contradictions which are intrinsic to the tasks of community development. Simple solutions may simply not exist.

2. PROJECT PLANNING IN COMMUNITY HEALTH

There is considerable variation in style and complexity among the planning and evaluation tools used for community development work in the community health field. Planning protocols based on educational or managerial models arc not necessarily appropriate to community development work. Traditional planning protocols tend to be built on a linear - or at best circular - model, moving from the identification of needs, to goal setting, to objectives, to strategics, to implc-mentat ion and to outcomes which arc then evaluated for effectiveness and efficiency, with the insights gained being fed back into the next round of the planning system. The emphasis is on reaching the goals and achieving hoped for outcomes.

In community development work however, the process of program planning, implementation and evaluation is of comparable importance to project outcome (for example, where the roles of the worker and the participants change during and through the process). This developmental aspect should be reflected in the planning tools. Likewise the common view of evaluation as being tacked on to the end of a program is not appropriate. Evaluation, reviewing how we are going and learning from our experience, should be an integral component of the planning and implementation process from the beginning.

Described below arc examples of planning and evaluation tools currently in use in a few Victorian community health centres (CHCs). It is not suggested that a single planning model could be developed that would cover all community development work in the health field. Each CHC, district health council or other group must develop tools that reflect its own philosophy and arc appropriate in the local context. The tools presented here are offered as examples of how a few CH Cs arc presently approaching the task.

The planning tools presented here have been developed from a model previously used in the health promotion field in NSW. In Victoria they were adapted by a number of Community Health Centres including the Fitzroy CHC in 1985 (in its well known mult i-colourcd scheme) The format discussed below is that currently in use al Kensington CHC. Some features of the Fitzroy scheme arc presented also. They are not fixed in concrete and will continue to be updated periodically and improved.

The two CHCs represented in this section have invested a considerable amount of time and energy in discussion among staff and management and in consulting with their local community, as part of developing their perspective on community health generally and the philosophy, values and aims of their centre in particular. The specific planning and evaluation tools which are presented below were developed within this framework ensuring that they arc consistent with and reflect this perspective.

A final warning note. The proper use of the various forms presented below is not always easy. This is not so much due to the forms as to the tasks which they arc designed to help with. Planning and evaluation, done properly is not always easy either.

2.1 Kensingtonc2)

Background

Kensington C!HC was established as a result of local initiative in the early 1970's in a densely populated suburb three kilometres west of Melbourne. It has a large ethnic population, many low income families/houschold5, and a lot of high rise public housing. The basic values underlying community development are widely shared in this community. The staff and the committee of management of the health centre share a strong commitment to the community development approach to health and this is reflected clearly in their current (1987-88) Ilealtb Services Agreement:

> "The philosophy of Kensington Community llealth Centre is to encourage people to *be* involved in their own health care in a way which enables individual people, families, and the community to function at an optimum level. The Centre exists to help local people make decisions about their health, living conditions, finances, their work and any questions concerning daily living. Its approach is total health care with an emphasis on prevention.
>
> "This in turn leads to an emphasis on the process of *how* work is done as well as the results. The crucial element of a developmental approach is to empower local residents, particularly those who arc disadvantaged. Community development work is thus not merely ongoing service delivery in groups; it enables people to organize together around their own needs and concerns in order that they become more in control of the processes which affect their lives."

Also, in their plans for community development work it is stated that:

"...two main priorities have been adopted for 1987-88. These arc, firstly, "ethnic affirmative action", adopted because of the Centre's awareness of the need to respond further to the high ethnic population of Kensington. Secondly, the Centre has identified "anti-poverty awareness and action" as an important priority because of the link identified between poverty and ill health."

It will be seen how their planning tools are deliberately linked to this *empowerment* aim (which reflects the importance of the *process* of community development work) as well as to the two current priority aims outlined in their Health Service Agreement.

The modifications which were introduced at Kensington were developed by the staff in response to requests from their committee of management for more specific information about goals and performance indicators in their community development work. Their planning process is now more rigorous, particularly through a greater emphasis on aims, goals and tasks and they are more accountable to the committee of management for their project work. The centre's accountability to their community is also strengthened through the involvement of the participants in the evaluation process. The worker is encouraged to be more aware of the empowerment aim through the course of the project; charting the changing power relations as the project progresses.

The Pink Proposal Form

This form must be filled out by staff preparing for any community work and is presented to the planning and program sub-committee of the centre (made up of staff and committee of management representatives) for approval. A guide to using the form is also provided; the preamble to this guide is worth quoting in full as it illustrates the integral and ongoing nature of planning in community work:

"The Proposal Form is intended to help you plan and organise your work. It is most useful if you use it as soon as you begin to plan a program; i.e., the moment you begin to do something more concrete than just thinking generally about it and sparking off ideas. The questions asked are meant to elicit the essential information required to properly plan a program, assess its potential value and feasibility and outline its steps and timing. You probably won't be able to answer all the questions at once - or at first - but getting the information and making the decisions required to answer all the questions is what the planning process is all about. The form is here to make sure you ask all the necessary questions, answer them adequately and then keep a record of those answers for future reference and to share with others."

The actual questions on the form are presented in block letters; selected comments from the Guide are then listed (with our comments in italics)

Q1. HAVE YOU DISCUSSED THIS PROPOSAL WITH OTHER STAFF?

Q2. DID YOU USE THE GUIDE TO HELP YOU FILL THIS OUT?

Q3. GIVE A BRIEF DESCRIPTION OF THE PROJECT' IN ONLY A FEW LINES, INCLUDING ITS TARGET GROUP.

Write this question last, as it should really summarise your project in a nutshell. Be specific about the exact target group, eg. low-income, first-time pregnant women living in Kensington.

Q4. DESCRIBE WHICH NEEDS YOU ARE TRYING TO ADDRESS AND PROVIDE ANY RELEVANT BACKGROUND.

Detail the needs here, not the solutions. You should, where possible, describe the needs from different angles, eg:

- what local people *say* is the need (eg. 'I'm lonely'),

- what concrete expressions there are of these needs (eg. the number of enquiries),

- what the statistics say or what the need seems to be compared to other areas (eg. Preston has a well-used public dental service),

- what other local workers or "experts" say (eg. the infant welfare sister says many mothers don't know enough about immunisations).

It is also important to know what you do not know. What information are you lacking? If it is a lot or if it is crucial, perhaps stage one of the project may be to investigate the need further. Include any assumptions you're making about the need (eg. 'I'm assuming local residents will think this is important although they don't know about the issue yet'). Summarise any relevant background information.

(Note the link between planning and research.J3)

Q5. DESCRIBE HOW THIS PROJECT' WILL TRY TO TACKLE THOSE NEEDS

Detail the solution and why it is a (part) solution. Explain the methods and activities, how the project will be organised, why and how it will meet the needs. Include any assumptions you're making about the method or the target group (eg. this is an appropriate way for Turkish women to organise).

Q6. IS THIS PROJECT' A PLANNED PART OF A WIDER STRATEGY FOR ONE OF TI-IIS YEAR'S PRIORITIES? IF NOT, HOW DOES IT FIT IN WITI-I THOSE PRIORITIES?

(Tbis refers to the Centre's current two key priorities for community development- anti-poverty and ethnic affirmative action . Every year the Centre as a whole chooses its priorities and prepares overall strategies for tackling these priorities. If the proposed project does not address these priorities, the onus is on the worker(s) to justify its inclusion more rigorously - in answer to questions 6 and 7. Narrowing the focus to two key priorities was based on the Centre's realisation that it was trying to do too much in responding to any perceived need.;a change from reactive to proactive planning)

Q7. GIVE SOME JUSTIFICATION FOR **US** DOING TI-IIS PROJECr **NOW** (GIVEN OUR CENTRE'S PHILOSOPHY, OUR CAPACITIES, CHANCES OF SUCCESS, SKILLS AND PRIORITIES, ESPECIALLY IF YOU ANSWERED NO TO QUESTION SIX).

Programs should be justified not only on the basis of the importance of the issues concerned, but also on the feasibility and usefulness of the proposed actions. If you can't support the program on all these grounds, it is worth reconsidering whether you should be doing it at all. Perhaps a different approach is required or another area of need should be considered.

Q.8. WHAT IS THE VIEW OF OTHER RELEVANT COMMUNITY GROUPS OR AGENCIES ABOUT THIS PROJECT'?

Q.9 STATE CLEARLY ALL THE PROJECT'S AIMS, GOALS AND MAIN TASKS.

Aims: the overall, optimistic (perhaps impossible) vision of what we intend to do (eg. to enable all residents to have a say in KCHC decision-making, to inform all residents about AIDS). You should always include at least one aim relating to empowering participants. This will describe what your project hopes to achieve in enabling local residents to have more control over their lives or the community's affairs (eg. to maximise local residents influence in affecting Health Department policy, or to enable group members to take control of the group).

(Perhaps community development planning should also include a ***consensus-building aim,*** *so that both empower-*

ment and consensus-building objectives and strategies are built into the planning process.)

Goals: Detail all the goals, ie. the steps you need to take, for each aim. Each goal should be specific, achievable and measurable, leaving little doubt about what is to be done and the result intended. (eg. publicise the beginning of a chronic back pain support group by July 1st.)

Tasks: Concrete, clearly defined and measurable.

(The Aims/Goals/Tasks section is on a separate sheet, and workers are encouraged to use as many sheets as required to document the process thoroughly for each aim.)

Q10. WHAT IS THE EXPECTED TIMETABLE FOR THE PROJECT?

How will you know if the project ceases to be viable and what will you do then?

Q11 DESCRIBE YOUR ROLE(S) IN THE PROJECT.

This is different from describing the aims of the project, but should link in with the empowering aim. For example the main aim might be to inform the community about AIDS, but your role might be to organise the campaign or to facilitate a group of high risk residents to organise the campaign itself.)

(Fitzroy CHC has another important question at this stage of the planning process: "How do you plan to terminate your involvement in the program?" Their planning guide points to the risk of dependency in participants and asks workers to think - at the planning stage — about what indicators of reduced involvement they will be looking for along the way.)

Q12 HOW MUCH WORKER TIME WILL BE REQUIRED, AS WELL AS ANY OTHER RESOURCES?

Q13 HOW MUCH COMMUNITY WORK TIME DO YOU GET PER WEEK? WHAT OTHER PROJECTS ARE YOU INVOLVED WITH, AND WHICH YOU MAY HAVE TO CUT BACK, IN ORDER FOR YOU TO WORK ON THIS PROJECT?

Q14 WHEN WILL PROJECT BE MONITORED NEXT AND HOW WILL YOU ELICIT PARTICIPANTS' VIEWS ON ITS OUTCOMES?

We want to encourage workers to get more feedback from participants on what benefits they have got from their involvement. Start thinking of this now, as you might need to gauge people's current situation first to use as a comparison later on.

(Evaluation built into the planning; a conscious effort to involve participants in monitoring and evaluation.)

Q15 ANY OTHER COMMENTS?

(* see Appendix for example form)

The Mauve Monitoring Sheet

(Each program is monitored by a small group of staff meeting every three months. A copy of the Aim's/Goals/Tasks sheet is attached to the mauve monitoring sheet which is filled out and presented to the small group.)

Q1. ATTACH A PHOTOCOPY OF THE AIMS GOALS AND TASKS SHEET FROM THE PLANNING FORM AND UPDATE WHAT HAS BEEN ACHIEVED OR CHANGED.

If your aims have changed significantly it would be better to write out a new pink planning sheet.

Q2 DESCRIBE HOW THE PROJECT IS GOING, INCLUDING ANY MAJOR CHANGES OR DEVELOPMENTS IN THE PROJECT

Summarise the progress; describe any major developments or changes in relation to:

- overall direction or orientation,
- target group,
- staff/community members involvement in the project,
- reaction by other community groups etc,
- resources.

What action have you taken or are you going to take, to respond to these developments' Is this still consistent with the philosophy and priorities of KCHC!

(Note the evaluation of process as well as outcome.)

Q3. WHAT ARE PARTICIPANTS GETTING OUT OF THE PROJECT? HAVE YOU HAD ANY FEEDBACK FROM THEM OR THE COMMUNITY? HOW HAVE YOU FOUND THIS OUT?

You could get this feedback from participants by:

- asking residents,
- group discussion,
- questionnaire,
- getting another person to speak to the group,
- your own innovative method.

Relate this feedback to your empowering aim(s) as detailed in your last proposal/monitoring sheet.

(Again evaluation of process as well as outcome. If a consensus-building aim were also included, an assessment of the goals/strategies used to achieve these aims could be a powerful evaluative tool for community development in health.)

Q4. IF YOUR PROJECT' IS NOT PART OF ONE OF **THIS YEARS PRIORITIES,** GIVE SOME JUSTIFICATION FOR US CONTINUING TO SUPPORT IT.

Q5. COMMENT ON YOUR ROLE IN THE PROJECT SO FAR.

Take a critical look at your effectiveness or usefulness in this project. Compare your current role with the role that you described in the planning sheet. What changes in your role have occurred? Should you amend your role now (eg. should you be taking more of a back seat role?)?

Q6. COMMENT ON THE USE OF RESOURCES SO FAR.

Q7. CURRENT TIMETABLE FOR ACHIEVING GOALS AND TASKS?

Q8. OTHER COMMENTS,

eg. lessons from this project that would be useful to share.

Q9. SUMMARY

of project's progress and current situation (in about five lines).

(' see Appendix for example form)

2.2 Fitzrny(4)

Fitzroy Community Health Centre has been through some turbulent times since it was first established in 1974 as the De Paul Community Health Centre, operating under the aegis of Melbourne's St Vincent's Hospital. Almost from its inception there was a strong demand from within the Fitzroy community for the health centre to be transferred to community control. One of the criticisms levelled at the hospital management regime was a failure to address the social health problems of the people of Fitzroy, a failure to undertake a community development approach to its work. The funding was transferred to a community based committee of management in 1985.(5)

Fitzroy is a small inner suburban municipality. It bas a relatively high proportion of public housing, a large number of ethnic groups within the community, a significant number of transient and homeless people. Parts of the suburb have also seen a considerable degree of gentrification over recent years and there have been strong moves to contract the involvement of the City Council in human services delivery and planning.

The new Fitzroy Community Health Centre was thus born out of a concern to address health and illness within a social context and on the basis of a strong demand for a service which would be directly accountable to the local community through an elected committee of management. It was born into a local culture which had an established tradition of social planning.

Around the time that the Fitzroy CHC was getting started there was growing pressure on community health centres to 'evaluate' their work; to be more 'accountable'. Basic to the Fitzroy approach is that there is no point in evaluating except on the basis of earlier planning and that both planning and evaluation need to be undertaken within a recognised accountability framework; accountability to the community as well as to the health planners.

The Fitzroy project planning scheme has provided a starting point for the development of similar planning and evaluation schemes in other community health centres.(6) The scheme is far more than simply a set of forms. The forms are drafted by staff, are considered and perhaps amended in the Programs and Services Subcommittee of the Committee of Management (which is made up of staff and committee of management members) before being ratified by the full Committee.

Along with the forms there has developed a culture which accepts the value of project planning, of evaluation and of accountability of staff to the committee of management and of the centre as a whole to its users and its local community generally.

The Fitzroy CHC planning scheme has developed considerably since it was introduced. Additional forms have been introduced for specific service programs. Other community health agencies may also be well advised to start simple and to build up their planning scheme slowly so that staff and committee of management members may grow into the system.

Fitzroy's Pink Planner covers much the same ground as has been described above. The (yellow) Final Assessment form used by Fitzroy covers similar ground to the Kensington Mauve Monitor but firms up the evaluation process by highlighting the importance of recording, immediately after the program's completion, any discernible results or effects, and any significant failures or successes in the program's planning or implementation.

The Final Assessment form is designed to elicit answers to two basic questions

(1) Did the program as a whole proceed in the way intended, and if not, why not? (Note especially any significant unexpected outcomes, good or bad; if so, why?

(2) What are the results and effects of the program?

This form also asks workers to try and assess the program from the viewpoint of the participants, including the question: "What was the outcome of strategies adopted to elicit their (ie. participants') evaluation of the program?" Workers are asked to include participants' evaluation (not just their passive feedback as respondents) as well as evaluating the process itself. This is an example of a centre strengthening its accountability to its community and adopting community development strategies within its planning and evaluation processes.

The full effects of a program may appear only after a long period of time, years perhaps, but much can be learned from making this sort of initial assessment soon after the completion of a project. The basic questions that Fitzroy CHC is asking in its Final Assessment form can be broken down into more specific, more answerable questions, such as:

- What was done? To what extent was the program plan actually implemented
- What happened? What was the result of that effort
- Does the actual result match the intended result or end product in the objectives
- Were there unintended consequences from program intervention
- Is the actual result (intended or not) satisfactory to meet the need? Were programs adequate, accessible, available, appropriate, acceptable in terms of participants and the target population?
- What are the explanations for the results achieved? Why did a planned effort work, or why didn't it
- How efficient was the approach in achieving the objective?

- What other activities should be undertaken?
- What activities should be discontinued as non-productive in terms of achievement of objectives?
- To what extent should objectives be adjusted to reflect the experience gained through program operations?

(• sec Appendix for example form)

2.3 User Feedback

Feedback from workers at Fitzroy Community Health Centre (where the forms have been in use for a longer time) has been overwhelmingly positive. A summary of views expressed:

- Workers are forced to research their proposals properly, thus avoiding the likelihood of duplicating the work of other agencies or of producing something that is not really needed in that community.

- It helps the worker to look at their overall workload, encouraging them to rationalise their time and prevent stressful overload.

- Workers find it easier to evaluate a project at its completion because the issues have been observed and recorded throughout; it is especially helpful in highlighting unintended consequences.

- The planning process permeates to other areas of their work; for example, some workers commented that they were far more effective in joint agency committees because they saw more clearly than before what questions needed to be asked at the appropriate time.

- It helps workers to be more self-critical and clarifies issues among staff.

- Workers find themselves more responsive to the need for changes in services and in the allocation of their time.

There was one main negative comment about this planning process. Because there was a two to three month delay between the initial thoughts on the project and approval by the committee the original impetus and enthusiasm in the community could be lost. In come cases more immediate action is required to capitalise on fragile local initiatives.

New staff members or those who had not been accustomed to systematically verbalising and writing down their thoughts were initially daunted by these forms. On the other hand the situation became a useful learning experience where more experienced staff members were available to help them with the forms. Any agency introducing project planning schemes such as these would be well advised to start simply and allow the scheme to develop as staff and management committee become more accustomed to the system. They should also ensure that support and assistance is available to people who are unfamiliar with the scheme.

2.4 Commentary

The forms and processes described in this section reflect a commitment to rigorous planning and evaluation within an accountability framework which is consistent with the philosophy and strategies of community development in the health field. Some of the key features are:

- evaluation is built into the process from the beginning,
- the system is owned by the users,
- participants are involved in the evaluation process, not just as passive respondents.

Used flexibly and creatively these planning tools can play an important role in consensus-building among fellow workers. Staff will be encouraged to discuss all stages of planning with other workers (as well as with the small group that monitors the program) and all workers with some involvement are invited to fill out their own forms. Used in this way people with different viewpoints and opinions can share their different assessments of progress.

Forms and processes such as those described above should not be used mechanically. We would suggest occasional checks back to one's underlying model of community development.(7) (Are we using empowering and consensus-building strategies as part of our planning and evaluation process?). We would also suggest conscious reflection on the linkages between the forms and processes used for planning and evaluation and the accountability relationships which they may express.CB)

These sorts of planning and evaluation methods, built into the workers' routine practice should not be taken as pre-empting longer term follow up evaluation; rather they provide the basic building blocks for such longer term studies, whether they are done by workers, managers or external evaluators.

3. SYSTEMATIC LISTENING

3.1 listening To The Consumer's Experience

There is nothing particularly new or radical about listening to people's experiences of being sick or of using the health system and feeding that back into the planning process. Stories in the press for example or complaints to politicians can have a dramatic effect on planning.

In fact, however, patients' experiences are not systematically brought together and fed back into the administration of health care nor the planning for future services. Administrative and planning decisions are generally based on the experiences and concerns of health professionals and managers, reported and summarised up the organisational hierarchy and complemented by quantitative information about attendances, bed days, admissions, deaths, operations, etc. A hierarchy exists through which providers experiences and perspectives can be collected and aggregated and fed into administration and planning (although possibly distorted somewhat as it is reported upwards).

No comparable mechanisms exist for collecting, systematising and feeding into planning and management the experiences of consumers. This is paradoxical because, notwithstanding the technological aura of modern medicine, the reasons that health and illness matter individually and socially are basically subjective; the experience of worry, pain, sadness and disability.

The power of anecdotal accounts of consumers' experiences have been demonstrated in several recent reports which have used consumers' stories as part of their data base. The Victorian Women's Health Working Party (1985/86) conducted an extensive consultation throughout Victoria, encouraging women to speak out about their experiences, their concerns, the barriers they experience to better health. The authority of the Report *'Why Women's' Health'* is undoubtedly enhanced by the liberal use of verbatim accounts to illustrate issues of concern. Another recently released report, based in large part on patient anecdotes (and the more powerful because of it) is 'Our Health Our Hospital', the report of the Royal Women's Hospital Community Consultation.(10)

Ad hoc examples of press reports of consumers' experiences or intermittent inquiries and reports only highlight the absence of routine mechanisms for systematically listening to consumers' experiences and summarising and feeding them into planning and administrative decision making.

3.2 Systematic Listening

The Victorian District Health Councils Program(ll) was established (from 1985) with the aims of enhancing consumer and community participation in health decision making; enhancing community understanding about health and strengthening the accountability of the health system to the community served. The Program bas an explicit commitment to affirmative action also; to make a special effort to give voice to groups which have been relatively excluded from being involved in health decision making previously. The Health and Social Welfare Councils Program in South AustraJia0 2) has similar goals.

An explicit part of their brief is to listen systematically to consumers; to their experiences of being sick and of trying to keep well and to their experiences of sick care and through this to contribute a consumer's perspective to health decision making. This is referred to as **systematic listening.** The significance of this approach lies in its emphasis on systematic as opposed to ad hoc listening or simply the stating of opinions.

Some of the key features of systematic listening are:

- listening first hand,
- targeted listening,
- collecting from a broad base,
- documentation,
- collecting our own stories,
- checking back,
- reporting.

Listening first hand. A bad experience can be passed on rapidly through many networks, its significance being distorted as well as multiplied. The real experience of one person or family becomes the apocryphal vehicle for the fears and concerns of many others. The first principle of systematic listening is to only record first hand experiences.

Targeted listening. DHCs are not passive, value-free ears. Whilst they are developing a whole range of ways of collecting stories from across their community, their commitment to affirmative action requires that they should be putting a special effort into listening to and documenting the experiences of people who have been relatively excluded from health service decision making previously.

Collecting from a broad ba.-,e. Any single set of consumer experiences will have been selected, somehow, through attending a particular meeting or receiving a newsletter or through having had a particularly bad experience and actively complained. This doesn't make those experiences any less valid. It just means that they are only representative of people who are like the selected group. It is not to be assumed that they are representative of the broader community. Correcting for the risk of skew base requires, firstly, thinking about who have we collected experiences from so far (and who have been excluded) and secondly, actively seeking out the experiences of people who might have been excluded so far.

People's experiences of being sick are amazingly varied. Individuals are different, diseases arc different, health care settings are different. How do you know when you have heard enough stories of a particular kind to start to draw some conclusions and perhaps make recommendations? Perhaps the simplest test is if you start to bear similar (first hand) stories and from different ficlci5.

Documentation. Crucial to good systematic listening is

documenting verbatim or semi verbatim the essence of each story. The power of each person's experience comes from the words that individual uses to describe it. Summarising people's stories runs the risk of losing the colour and the warmth, the mood, the experience. Longer stories, of course, might have to be summarised but should include enough quotes to convey the feelings.

Obviously it is important to preserve **confidentiality.** There is no need to record name and places and sometimes it might be necessary to change minor details to ensure confidentiality. The point of documenting anecdotes is to capture the patterns that emerge with respect to the experiences of lots of consumers. The anecdotes may not tally with what others believe 'actually occurred'; they represent the experience that that consumer has taken away from that episode. Considerations of natural justice require attention to confidentiality as well as avoiding the risk of defamation proceedings.

Collecting our own stories. The practice of systematic listening should not be thought of as professional surveyors coming in from outside and taking away people's experiences for laboratory analysis. Firstly, most community based organisations do not have the resources to contemplate such surveys, particularly if we are talking about a routine systematic listening capacity. Secondly, that sort of model is antithetical to community development principles.CH) Would such a process contribute to empowerment and consensus building in that community? Clearly not. Accordingly, this process is about involving people from that community or network in listening, collecting and documenting experiences.

Checklng back. For the same reasons the process of thinking about the significance of emerging patterns, identifying priorities and determining action should be one that involves the people whose health is at stake. There should be opportunities for consultation at least; in some situations direct involvement.

Being involved in collecting and analysing their own experiences can be empowering (for example, through increased understanding) and consensus building (through identifying common issues and sharing those which were previously not common).

Reporting. From the point of view of communicating to planners, administrators and politicians a key problem associated with having an adequate sample of fully documented stories from a range of situations is the size of the documentation and the time it would take to read it. Busy administrators and politicians like to have everything on one page. That is why they prefer a table of figures to a chapter of anecdotes. Under these circumstances it may be better to present a few representative stories, making it clear that they are representative of a broader collection. It might also be worth while ensuring that the stories are backed up by pressure from the constituency concerned to make sure they are listened to.

Over the last two to three years the first eleven pilot DHCs have explored a number of different approaches to the challenge of systematic listening. It has enriched the DHCs' work in many ways:

– increases DHC members' understanding of how the health system works, how it responds to consumer needs;

- alerting DHCs to gaps and deficiencies in service provision, some of which may be addressed through DI!C initiated projects;

- enabling the DHC to present a consumer perspective in consultations with other agencies and government departments;

- "fleshing out" basic statistical data with a human dimension, thus providing a social perspective to an issue, which other health data often lacks.

3.3 Examples

Health Days

Most of the DI!Cs have organised women's health days, partly information giving, partly getting together, partly systematic listening. They have been well attended and full of energy. Different approaches have been adopted with respect to collecting experiences on women's' health days.

The Strzelecki DHC organised a women's' health day in South Gippsland in 1986. (Women) members of the D!IC were identified as such by their lapel badge and undertook the task of talking to the women participants about their experiences, all of which were carefully recorded. The anecdotes were included as an appendix to the report of the day, distributed to participants.(l4) The overall picture highlighted a range of issues and needs, some common to women across the state, others particular to the locality. In South Gippsland, for example, the women's' stories pointed to an overwhelming need for a wider range of childbirth options (taken for granted in a large city) to be made available. The report of the women's health day organised by the Wimmera DHC is also availablc.(15)

Publicity

The Strzelecki DHC was exploring the issue of palliative care and wanted to learn about peoples' experience of terminal illness. Advertisements were placed in the local papers and health professionals were asked to assist the Council in making contact with families who had been touched by this experience. Some 16 anecdotes were collected which were included in the report of the project. The anecdotes provided depth to the DHC's deliberations on the issue and undoubtedly contributed to advancing the project to the next stage.06)

Discussion Programs

The education and discussion programs Exploring Health Care and Health Wise are two particular resources which can contribute to systematic listening.

Exploring Health Care is a 12 week (one night per week) discussion program about health and illness and the way the health system works. It commences with a strong emphasis on pooling and collecting anecdotes about people's experiences of illness and of being a patient. This provides a common information base and ensures that the health system

about which the later sessions deal corresponds to the shared experiences of the participants. The later sessions deal with more abstract issues such as heath funding, prevention and the politics of the health professions. It is essential to have this material anchored in real experiences. The Exploring Heath Care program is not for everybody. It has been most successful in groups which have adequate literacy and discussion skills and who feel comfortable with role plays and 'homework'.

Health Wise is a three to five week program which focuses mainly on the sharing of experiences and learning and discussion based more directly on those experiences. It is much more accessible as a discussion program and has a much wider application in the community.

Both Health Wise and Exploring Health Care use consumers' experiences as a basis for exploring the social context of health and sick care and for canvassing issues, priorities and possible solutions.

Surveys

Systematic listening has also been practised through more formal surveys such as the Preston Northcote Ethnic Youth Health Project,C17) the Loddon Women's' Health Research ProjectClS) and the Wodonga and District Older Persons' Needs Study.Cl9)

Ilaving listened carefully to the experiences of consumers, the next step for the DHC is to decide what to do. It may be necessary to undertake more detailed research or project work on the issue to help build up a fuller picture. It may be appropriate to get groups with common experiences together to find a common solution. The DHC may be able to directly communicate conclusions and policy recommendations to the planners to lead towards change in how things are done. Publishing reports which include representative anecdotes is clearly an important step in capturing the experiences of that constituency and communicating it to planners and decision makers.

The Speak Out

Another approach to communicating to planners and politicians (which has been explored by the Melbourne DHC particularly) is the organising of a consumer speak out within the agenda of an annual general meeting or a meeting organised to discuss a particular issue. At the 1987 AGM of the Melbourne DHC six local residents talked about their experience in trying to procure adequate dental care on limited incomes.

At another meeting (the first 'National Health Club Luncheon') at which issues in neonatal care were considered, a consumer speak out about consumers' experiences in birthing was included on the agenda. On both occasions senior decision makers who were present registered clearly the broader perspective on those matters gained by listening to consumers' experiences.

3.4 Comments

Members of DHCs who have used systematic listening report favourably on the value of sharing in terms of learning and changing attitudes although it is sometimes hard to discipline oneself to purposeful reflective listening. Not all members have the same writing or listening skills and additional support may be needed.

It is also important to keep in mind the hazards associated with systematic listening such as lack of balance (eg only collecting anecdotes from people who have complained) and distortion (eg through hearsay).

Many consumers have been appreciative of the opportunity to talk about their concerns or their experiences of the health care system, participating with the knowledge that their perspective is contributing to their DHC's understanding of the real health issues of their locality and may assist in bringing about change.

The DHCs themselves have demonstrated the strategic value of systematic listening in terms of project success and in terms of the underlying process of community development.

4. THE DHC STRATEGY PLAN

4.1 Introduction

The first eleven district health councils (DHCs) were established (in Victoria) from early 1986. Eventually there will be 41 DHCs across the State. The purpose of the DHC Program is to contribute to improved health and improved health care by:

- enhancing community understanding of health issues,
- promoting community participation in health decision making, and
- strengthening the accountability of the health system to the community.

It is a very broad brief. It was evident from the beginning that a small organisation such as a DHC (initially with only 17 volunteer committee members and two staff) could not address all the possible issues across such a broad canvas. They would have to identify priorities. If they were to *be* effective despite their limited resources, DHCs would have Lo make sure their work was strategically focussed, actual change oriented. They would also need to have regard to their own development (in terms of group building, understanding, outside relationships, constituency development, etc) if they were to grow in strength over the succeeding years. In short, it was essential that they planned.(20)

Provision for all DHCs to develop strategy plans was included in the original Program guidelines, developed before the first DHCs were actually established.

Over the first twelve months most of the eleven pilot Dl-!Cs developed comprehensive strategy plans outlining their priorities and including sketch plans for the most important of the foreshadowed projects and activities. These strategy plans have generally proved to be valuable aids in helping the DHCs to maintain control of their own agendas, plan for their own development and ensure that their efforts arc strategically directed.

However, this first phase of strategy planning was a difficult process and the concept is still not embedded in the routine practice of all DHCs. There are still unresolved issues about the role of the strategy plan, most obviously the question of how to ensure that the plan remains a living current guide to action, rather than being simply a snapshot of our intentions at some time past.

Uncertainty is intrinsic to a planning approach aimed at achieving change in a field which you do not control. In this respect it is very different from planning which simply responds to projected trends.

There may be some useful lessons about planning in a community development context which may be drawn from this account of the experience of the DHCs with strategy planning.

4.2 Practice

The most common structure of strategy plans is as follows:

- documentation of problems and issues with respect to health,
- an assessment of the developmental needs of the DHC,
- an account of the projects and activities planned to address the health objectives of the DHC and its developmental needs,
- a workplan indicating how the various projects and activities were to be scheduled.

The concept of the 'project sketch plan' has been used to capture the essence of each of the foreshadowed projects and activities. The sketch plan for each project includes objectives, reason for priority, strategies and tasks, timelines, resource commitment and evaluation approach. Projects should be small, manageable and achievable.

There were no local precedents for the 'how to' of strategy planning. It was expected that DHCs would explore different methods and different approaches and that in due course the underlying elements of a methodology would emerge. This was encouraged by several workshops.

The **basic elements** of strategy planning which have emerged through this process are as follows:

1(a). Recognise the need to plan for specific health objectives.

1(b). Recognise the need to plan towards meeting the developmental goals of the group.

2(a). Document a list of health issues.

2(b). Identify the priority developmental nced5 of the group.

3. Conceive a range of possible and necessary projects and activities which correspond to the health issues and developmental nccd5.

4. Develop sketch plans for those projects and activities for which there is enthusiasm among the members and for which resources are available.

5. Review the sketch plans for practicability, contribution to heath goals, contribution to the development of the group.

6. Merge sketch plans into an integrated work plan.

A critical part of the strategy planning concept is the integration of health goals (for the district) and developmental goals (the development of the DHC). For example, a project group working on children's health issues was considering two possible projects: the development of a directory of services to facilitate smoother referral practices versus a discussion program involving young women attending toddlers' groups around the district. The DHC chose to work on the discussion program on several grounds, including the DHC's need to build its links with women in the district.

It is not a linear process like driving from point 1 to point 6. Within the overall framework, different parts of the plan take shape at different rates, with repeated checking and linking between the different elements of the plan so that the final product is a smooth coherent whole. The process takes place over a period of months involving general discussion, workshops, project groups and a final drafting group.

4.3 Experience

Within 6-8 months most DHCs had completed strategy plans which conformed to the broad outline indicated above. Over the next two years DHCs attempted to address the issues identified in their strategy plans, often in close accord with their original sketch plans(21).

Strategy plans provided important protection against the onrush of new challenges that DHCs faced in the early days. They were confronted with a huge variety of health issues and concerns from their local communities and with a myriad of papers and documents for their consideration from the Health Department. With only a limited amount of resources (people, time and money) at their disposal, it became imperalivc for them to set their priorities and control their agendas in accordance with a mutually planned and collectively owned strategy plan.

As members and staff developed more expertise and confidence with respect to health priorities and greater understanding of the environment in which they were working the tasks of identifying priorities and developing sketch plans became more routine. As DHCs gained more experience two key challenges to be planned for emerged:

– how to plan for their own development as a mutually supportive and effective group, and

– planning towards the development of a broader constituency which feeds into the DHC process, which consciously idcnlifics with the DIIC

The process is not always a smooth nor an easy one. Some members have expressed annoyance at being required to engage in a prescribed planning process. Some staff found the technical task and the process and developmental issues more difficult than apparently neat set of guidelines suggested. However with the accumulation of experience members and staff came more and more to appreciate the value of strategy planning in assisting them to work proactively rather than reactively.

4.4 Some Questions Arising and Lessons So Far

Health outcomes and the developmental process. The experience of the DHCs has highlighted the contradiction between the achievement of 'outcomes' (well planned strategic change initiatives) versus the 'organic' developmental process which will ultimately make those outcomes achievable.

There was pressure on the DHCs to move rapidly into developing their strategy plans, in some instances before the group building process had really got underway, before the disparate individual members had evolved into a coherent collective.

There is a contradiction between asking consumers and community members to prioritise competing issues and to identify the most effective strategics for achieving change at a stage when many of them were not familiar with the full range of issues before them and not yet fully aware of the deeper structures determining those issues.

Likewise, there is an internal contradiction in expecting strategy planning that fully recognises the developmental needs of the committee and of the DHC generally when the newly appointed members may still be coming to grips with the aims and functions of Dl!Cs and the extent and complexity of the field in which they were working.

The relationship between staff and members in the planning process. The DHC's experience highlights also a series of questions about the role of staff versus members in the planning process. Fundamental to the concept of community development is the accountability of staff to the members. What then should the role of the staff be in the planning process: as technicians to listen, clarify and re-present for decision, or to do all the work or to do none of the work? DHC staff have worked in all of these ways from time to lime. Ultimately, the most important measure of accountability is that the organisation owns and has control over the plan.

Neither strategic planning nor community development arc easy. To undertake them both at the same time is difficult. It is certainly more complex than could be simply prescribed in a set of rules.

How to remain a living current guide. The environmcnt in which community organisations arc operating is constantly changing: ncw local initiatives or demands arise; new government funding or legislative proposals need to be rÉ;;A;;;d;d to; or a planned project may take much longer than expected, or produce unexpected outcomes that effect the strategy plan. A strategy plan should be more than a snap shot of what we were thinking some time ago. It should be a living document under constant review, updated on a regular basis. Decisions to modify the details of the strategy plan to encompass such developments are taken in every meeting. The question remains: how do you update the strategy plan (either regularly or continuously) to include such decisions without involving a prohibitive burden of paper work and still maintaining a sense of group ownership?

The most common approach to date is to have two copies of the plan, one of which is bound and dated and the other is kept in a ring binder as the living evolving version. New sketch plans can be added to this loose leaf version as they arc written or updated. The priorities list should be added to incrementally and reviewed formally when the full strategy plan is revised.

Who or what is; the strategy pl.an for? Underlying a lot of the above questions is this question about the purpose of strategy plans. It is clear that a major part of their role is to facilitate DIIC planning; agenda control and maintaining a strategic focus. Ilowcvcr, at a Program-wide level strategy

plans have an additional accountability role in relation to government (and other interested parties) and arc also an important part of the public face of the Dl-!Cs.

The Dl-!Cs commenced with an obligation to plan, rather than being allowed to gradually embark on their very broad brief and undertake more formal planning when and if the Dl-!Cs recognised the need to do so. The requirement to develop strategy plans became for some an onerous burden and at times this may have been a barrier to building a group commitment to the process.

4.5 To Be Continued

This account of the DHCs' experience so far with strategy planning possibly raises more questions than it reveals answers.

Among the more difficult questions is the basic contradiction between the pressure of optimistic expectations of significant strategic change (outcome) versus the slower unforceablc developmental processes, which arc in fact essential if the strategic initiatives are to be successful.

Nevertheless, the experience has been successful in that useful strategy plans have been developed and have become an important part of the steering mechanism for Dl!Cs. A lot of the difficulties have in fact been overcome and the skills and experience that has been accumulated will ensure that the process is never as difficult again. The process of planning is an important educational opportunity in relation to the health issues as well as the skills of planning.

Working to achieve change through community development is intrinsically difficult. Over their first three years the DI!Cs have demonstrated how the disciplines of strategy planning can assist with keeping in view a clear and implementable agenda of change.

5. PATCH

5.1 Introduction

PATCH, a Planned Approach To Community Health, has been developed within the Centre for Health Promotion and Education at the Centres for Disease Control (CDC) in Atlanta, Georgia. They have worked with several pilot communities in implementing and evaluating it.

The program is tightly structured and comprehensively documented. The structure is based on the PRECEDE model of health education.(22) This model emphasises the links between behaviour and health but the program allows for the social and economic determinants of behaviour to be addressed also.

In 1987 a PATCH workshop was held in Sydney. The workshop was organised by Robert Cumming, Department of Community Medicine, Westmead Hospital, Westmead 2145, telephone (02) 633 6677. Further information can be obtained from Marshal Kreuter, Director, Division of Heallh Education, Centre for Health Promotion and Education, Centres for Disease Control, Atlanta CA, USA, 30333. Phone (401) 329 3832.

5.2 The Elements of PATCH

PATCH is designed to help communities plan, implement, and evaluate health promotion and health education programs. Working as a team, representatives of state and local health departments, the community and the Centres for Disease Control (CDC) form a partnership to identify and meet the priority needs of the community. PATCH provides a forum through which these partners cooperatively identify health problems and then plan, conduct, and evaluate intervention activities.

The basic structure of PATCH, as promoted through CDC, includes the PATCH partners, the PATCH components and the workshops.

The PATCH Partners.

State Health Department. The state health department makes a commitment to provide technical assistance and support to community based health programs within the initial PATCH community.

Community. A PATCH community can be an area such as a city, county, district, or region. The community's PATCH team consists of a local coordinator, a core group, and a community group.

1. **Local Coordinator.** The local coordinator has primary responsibility for coordinating PATCH activities in the community. He or she will usually be someone in a local or regional health agency who has responsibility for health education.

2. Core Group. The core group consists of members of the community group who make a long-term commitment to the PATCH effort. The core group should consist of at least three (preferably six to 12) people who are willing to address

health issues and problems in their community. The core group's responsibilities include:

- assisting the local coordinator with the program's administrative functions,
- helping to identify the resources necessary to accomplish the program's objectives,
- assisting in carrying out interventions.

3. **Community Group.** The community group consists of people who are willing to participate. Often the community group comprises private citizens, political office holders, and individuals from service organisations and private companies. The community group's responsibilities include:

- participating in the development of program objectives,
- serving on working committees,
- assisting in the implementation of program activities.

Centres for Disease Control (CDC) - CDC's Division of Health Education will provide training and technical assistance to the state and community.

The PATCH Components.

Community Mobilisation. State health department staff with the assistance of CDC identify people in local communities who are willing to participate in a program that addresses that community's health issues and problems. These community leaders are introduced to PATCH as potential core group or community group members. A general health education campaign provides information to the public as PATCH activities progress so that other community people have frequent opportunities to participate.

Community Diagnosis. Community members determine:

- the community's leading causes of death and illness,
- the behaviours and conditions that contribute to those causes,
- what influences those behaviours and conditions.

In examining the community's health problems, activities include collecting morbidity/mortality data (some of which are provided through CDC), conducting a community opinion survey, and conducting the Behavioural Risk factor Survey. The community group develops specific and measurable community objectives and assists in identifying target populations for health care intervention.

Community Intervention. Having identified priority needs, the core group in consultation with the community group:

- identifies existing community services and interventions that can be helpful,
- plans and implements interventions.

The PATCH partners develop a comprehensive work-plan to achieve the objectives determined in this way. Methods will be developed to measure the process and impact of each intervention. More generally, mortality data, the Behavioural Risk factor Survey data, and public opinion information will be re-collected at three-year intervals to monitor the health status of the community.

The PATCH Workshops.

The program is structured around a series of six workshops run with the nominated members of the Community Group over a twelve month period. The content of the workshops is described in the PATCH Manual as follows:

Workshop 1.

Discuss the impxtance of data

Prepare for the Behavioural Risk Factor Survey (BRFS)

Prepare for toe Community Opinion Survey

form committee to undertake associate tasks

Workshop 2.

Examine mortality and other data

Examine completed Community Opinion Survey data

Identify priority health problems

Discuss links between behaviours and leading causes of death

Workshop 3.

Examine completed BRFS data and any other additional data

Identify priority behavioural and non behavioural risk factors

Develop community objectives and behavioural objectives

Brainstorm ways to share community data and priority health issues with organisations and the community at large

Workshop 4.

Select health problems and behaviour(s) to be analysed during Workshops 4 -6

Determine target populations and health education strategies

Workshop 5.

Select and plan intervention strategies

Identify resources

Workshop 6.

Develop work plan and incorporate evaluation

Design master timetable, and make dates and tasks for implementing activities

5.4 PATCH In Australia

We are aware of three PATCH based initiatives in Australia.

The Queensland Health Department has incorporated PATCH into its Health 2000 Program. The first pilot is being implemented in Dolby, population 15,000. The first core group workshop was held in April 1988.

At Arana in far west NSW the PATCH principles are being used to focus community attention on major risk factors.

A PATCH pilot in Bathurst, NSW, has also commenced with NHMRC funding.

5.5 Critique

In several important respects the conceptual underpinnings of PATCH are not consistent with a community development approach to health, at least as conceived within this Project. The scheme is structured around the risk factors concept and the interventions, designed to change risk factor prevalence, are conceived primarily in behavioural and educational terms.(23)

PATCH does not appear to have a theory to understand the unequal health experiences of different social classes and racial groups. There appears to be little scope for deliberately empowering strategies in community development terms. The focus on risk factors and measurable outcomes diverts attention from the social relations of illheailh anci the process issues involved in community health work.

Although some PATCH projects arc being piloted in Australia, it is too early lo draw conclusions on the basis of first hand experience.

Denise Fry attended the 1987 PATCH Workshop in Sydney on behalf of the Australian Community !!ealth Association and prepared a critical assessment of PAn:I-I.(24) In summary her conclusions arc as follows:

Benefits

PAT(:!! presents relevant epidemiological and health status information to clearly defined communities. This process has an educative function and can also stimulate action to address the problems.

The workshops encourage health service managers to place community participation on their agendas.

Limitations

It lacks sophistication in its handling of the concept and practice of community participation. It appears lo be quite inflexible and uses an overly standardised consultation procedure. There is tension between the program's community participation goals and the systematised and prescribed content of workshops and surveys.

There is insufficient emphasis on local strategy development. There is not enough time to develop imaginative or innovative strategics. There needs to be greater interaction between actual program implementation, evaluation, and the planning process, in order to make programs more relevant to local communities.

6. CHASP

6.1 Introduction

CHASP stands for Community Health Accreditation and Standards Project. It is a system for improving and assuring the quality of community based health services. It consists of a set of standards and a review process that can assess the extent to which a community health centre or service has achieved the relevant standards.

The Australian Community llcalth Association (ACIlA) has been funded by the Commonwealth Department of Community Services and Hcalth to develop CHASP across Australia. AC!-!A's brief is to assist stale health authorities and other organisations who deliver community health services to establish systems of standards, quality assurance and/or accreditation for their community health services.

The diversity of community health services and structures within and between states requires a ncxiblc approach to the setting up of systems of standards and review which arc appropriate to the neecLs and conditions in each state.

6.2 Development of the CHASP Standards and Review Process

The initial development of what has evolved into tlic Cl-!ASP standards and review process was done in NSW in 1982/3.(25) Further field testing was undertaken in 198/i/5 at fourteen community health centres in Victoria and South Australia resulting in a rewritten and expanded set of standards published as a Manual of Standards for Community Health.(26)

The standards arc divided into the following sections:

1. Assessment and Management of flcalth Problems
2. Early Dclcction
3. Prevention and Hcalth Education
4. Community Liaison and Participation
5. Rights of Consumers
6. Client and Program Rccord5
7. Staff Education
8. Research, Planning and Evaluation
9. Quality Assurance
10. Management
11. Work and its Environment.

Principles. For each of these sections there is articulated an underlying statement of principle from which the standards with respect to that area of work are derived.

For example, the Principle for Section Ii, 'Community Liaison and Participation' is as follows:

"An accrcditablc community health service shall have a high level of mutual exchange and integration with the community it serves. Community participation will be actively developed to increase the health centre's capacity to effectively address health issues in lhat community."

Standards. There arc between four and seven standards

in each section, based on the statement of principle for that area. There arc six standards in Section 4 (Community Liaison and Participation, above), entitled:

Comprehensive knowledge of the community,

Liaison with agencies,

Informing the community,

Accessibility and availability,

Community input,

Community management.

Each of these standards are cast in a prescriptive form, for example, Standard 4.5, Community Input, provides that:

"The community health centre/service will ensure community groups and members actively contribute to identifying local health issues, setting goals and planning and implementing activities."

Indicators. For each standard there are a set of indicators designed to guide surveyors in assessing the degree to which the standard is achieved. These indicators are written in the style of hints, things to look for.(27) For Standard 4.5 (Community Input, above), the indicators include:

Health centre activities developed at the request of community groups,

Opportunities for community members to contribute to the organising and running of activities on a voluntary basis,

Advisory committees, etc

CHASP also includes a process of **review** for assessing the degree to which a community health centre has attained the standards. The review process includes a preparatory questionnaire followed by an on-site review by a team of (peer) reviewers from the community health field. The reviewers collect information from a diversity of sources including documents, sample records, a comprehensive schedule of interviews with staff, management and others and an inspection of the centre. Finally the review team writes a report including suggestions for service development. This report is presented for discussion with the centre at a feedback session.(28)

6.3 Implementing CHASP Across Australia

Community health standards (and/or accreditation) programs based on CHASP are presently being implemented in Victoria and in South Australia and in several area health services in NSW. CHASP project officers have been appointed in South Australia and Victoria, jointly funded through ACHA and the relevant state authority.

In South Australia the project is overseen by the interim South Australian CHASP Committee. Introductory seminars, reviewer training programs and CHASP reviews at several community health centres have been undertaken so far.

In Victorian a range of organisations are collaborating in the introduction of the Victorian Community Health Standards Program.(29) This is being piloted in a range of community health centres in Victoria under the oversight of a representative Program Development Committee.

The model being explored in the Victorian program differs in two respects from the basic CHASP model. Firstly, it is not an accreditation program in that it is not intended that any certification of 'level of attainment' will flow from (or be withheld following) the review process. Secondly, before the review takes place, there is a preliminary interview with representatives of the centre with a view to agreeing on the standards which are most relevant to that particular centre. Community health centres differ widely in several respects; the intention is to establish an explicit link between the standards and review process and the centre's agreed role statement and objectives.

The Victorian Program will use the CHASP peer review process. All reviewers (usually community health practitioners) are required to participate in a training workshop. The review team consists of an internal staff member who represents the centre under review and two external reviewers who arc community health practitioners from other community health centres. The review is conducted over a two day period at the health centre and an additional interview is arranged with representatives of the relevant Health Department regional office.

At the time of writing (October 1988) CHASP reviews have been conducted at four community health centres in Victoria.

Introductory seminars on CHASP were held with the ACr Health Authority in September 1987. It is hoped to do further work in the future.

In NSW the management of community health services by area health boards in the metropolitan areas and public hospitals in country areas necessitates an area by area approach. In Western Sydney the ACI-IA is assisting several area health services to establish a cross area quality assurance review program for their community health services. A program of CHASP reviews at eight community health centres will be completed by December 1988. The Greater Newcastle Arca Health Board has endorsed the CI-IASP standards as being the most appropriate standards to guide its community health services. In rural NSW the ACHA is working with the Central West and the South West Regions of the Department of Health. Reviewer training has taken place and CHASP reviews at Albury and Forbes community health centers arc scheduled for November 1988.

6.4 Who Shall Accredit Community Health?

CHASP and ACHA are not the only bodies interested in accrediting community health in Australia. In fact there is some competition between CHASP and the accreditation program operated through the Australian Council of Healthcare Standards (ACI-IS). ACHS was formed in 1974, initially as a joint project of the Australian Medical Association and the Australian Hospital Association, later with several other professional health bodies joining. It also has representatives of state health authorities. The main focus of ACI-!S has been the survey and accreditation of hospitals.

Over the last couple of years the question of who should accredit community health has surfaced, particularly in relation to community health services which are administered through hospitals. The ACHS has some expertise in the review and accreditation of hospitals and argues that it makes sense for community health services in the latter situation to be jointly accredited along with the hospital.

However, ACHA believes that the standards for community health and the proposed review process developed by ACHS(30) are not adequate to guarantee quality and accountability to governments and consumers.

ACHA argues that the principles and values of community health call for an accreditation system that is directly accountable to the community health field; a standards program that works unambiguously towards strengthening community health theory and practicc.(31)

ACHA is currently negotiating with ACHS with a view to an agreement that community health review undertaken through the CHASP system will satisfy ACHS's accreditation requirements for community health administered through area health services or public hospitals.

6.5 Comment

The CHASP system was designed to serve as the basis for an accreditation or standards system (as in the Victorian model).

The manual also serves:

- as a set of guidelines with respect to service development,
- as guidelines for consumers about what their community health service should be able to offer,
- as an evaluation model,
- to demonstrate to policy makers and consumers that the community health field is maintaining its standard5.

CHASP has a special significance in this paper because it is based on a philosophy of evaluation and accountability which is quite different from that underlying several of the other mechanisms presented. QUAC (Section 7, below) and the health service agreements program (Section 8, below) both assume a form of accountability in which quantitative performance measures arc reported from the workface, up through the hierarchy until ultimately, in aggregated and summarised form, they are available to the minister.

CHASP (and the Hospital Accreditation Program run by the ACHS) recognise that most of what happens at the workface cannot be neatly quantified and reported up the hierarchy in this way. Instead standards for excellence are defined and for each a range of possible indicators are developed. The review process is undertake by trained reviewers who arc from the community health field (or from the hospital field in the case of hospital accreditation); it is a peer review process. Nonetheless it is accountable in that the manual of standards and the process of review are public.

Under the standards approach, the community health agencies (or hospitals) are accountable to government and to the community in relation to their participation in the standards program and in relation to the conclusions and recommendations of the reviewers report. Agency management arc accountable for the standards of care and service across the agency. The health workers are accountable in relation to the delivery of services and programs. Under the standards approach these two sets of tasks are seen as different, requiring different evaluation and accountability mechanisms. Under the quantitative performance reporting models they are different only in terms of scale, degree of aggregation.

6.6 Contacts

The CHASP Manual of Standards for Community Health is available from AGPS bookshops or by writing to ACHA. The standards and the review process arc subject to copyright but ACHA encourages and will assist in their use. ACHA will assist with seminars, training programs or in the conduct of reviews.

S.A. Project Officer:
Daina Neverauskas,
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(08) 232 0133

Victorian Project Officer:
Russell Renhard
Northcote CHC,
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7. QUAC c32)

7.1 Background To QUAC

The acronym QUAC derives from: Quality, Utilisation, Accountability and Cost. The QUAC Project set out to develop measurable objectives for community health and corresponding performance indicators.

The need to develop appropriate evaluation practices was highlighted in 1973 in the original Commonwealth policy statement which launched community health in Australia.C33) It was re-emphasised 12 years later in the (Victorian) Ministerial Review of Community Health(34) which suggested that pilot studies in relation to evaluation practice should be encouraged.

The QUAC Project was conceived as a pilot community health evaluation project sponsored by the Planning Division of the Health Department of Victoria from early 1986 and undertaken in close partnership with the six participating community health centres.

It is important to locate the QUAC Project in the policy climate of the time in which it was initiated: Victoria, late 1985.

Within the community health field there was a growing demand for better tools for planning and evaluation, a growing willingness to explore the area. There was a continuing frustration with the reporting system which the Department required community health centres to use, in particular, its emphasis on headcounting and its inappropriateness for reporting community development work.

At the level of the State Health Department the policy environment was dominated by the 'management-by-objectives' school. According to this theory the key to managing the health system was to require hospitals (and other health agencies) to specify their objectives and to agree to appropriate performance indicators. Once this was achieved the role of the central authority was simply to hold them to their commitments and/or to negotiate changes in those objectives. At this time there was also a palpable lack of sympathy in the upper echelons of the Department for the philosophies and rhetoric of community health.

Within this broader policy environment the QUAC Project was initiated from within the Planning Division of the Department. In retrospect its ambiguities are striking. It appears as a tactic to mediate the tension between the community health field and the managerialism dominant within the Department. It would articulate the objectives and recast the reporting of community health so that it could be explained to the managerialists, whilst at the same time using the increased focus on objective setting to encourage more attention to planning and evaluation within community health.

The basic goals of the Project were expressed as follows:

Quality: How can we ensure that community health programs and services are of high quality?

Utilisation: How can we ensure that appropriate services and programs are developed and utilised by the community?

Accountability: How can we ensure that services and programs are accountable to the local community and to the funding bodies?

Cost: How can we ensure that we are providing services and programs in the most efficient way possible?

7.2 Aims And Objectives

The overall aim of the Project was to develop and implement an appropriate system of accountability and objective-setting for community health centres and services.C35)

The more specific objectives were:

"1. To develop a standardised set of performance indicators for all CH*Cs,*

2. To help CHCs develop measurable objectives that match priorities set,

3. To develop a system of accountability to ensure that CHCs are accountable to consumers, their communities and funding bodies, and

4. To develop a system of accountability for the Health Department Victoria to ensure that funding departments are accountable to the agencies they fund and to the consumers for the adequacy of the support and resources they provide."

Six CHCs were invited to take part in the first pilot stage of the process. They were chosen to reflect the diverse range of communities served: city, country, large and small, medical and non-medical, areas with young families, the aged, multicultural groups. The Project was implemented as a partnership between the committees of management and staff in the pilot community health centres and the QUAC team.

7.3 The Workshops

The centre piece of the Project was a series of six intensive workshops with each CHC conducted by the QUAC team with committee of management members and staff

Part of the underlying rationale for the workshops was the goal of wider discussion and increased awareness about the objectives of community health and skill development in the practicalities of planning and objective setting.

The explicit purpose of the workshops was to define and adopt 'key performance areas',C36) 'key performance indicators' and 'performance measures' which would express the objectives of each CHC and provide a framework for evaluating those objectives.

These concepts were critical elements of the QUAC approach. They were defined as follows:

1. Key Performance Areas: areas of activity and work that are important for the health centre to be performing effectively in. Eg: health education, client services.

2. Key Performance IndicatorsJ36) the criteria for knowing whether or not the activities/work in your performance area are a success. Eg: accessibility, availability, satisfaction.

3. Performance Measures: ... tell you what the performance indicator indicates; ... an amount or kind of some-

thing that exists at a certain time. Eg: the number of people who attended, feedback, atmosphere.

4. Standards: levels of achievement that are held to be desirable ... ideals to be worked towards.

During the course of the six workshops (for each CHC) the participants moved from general discussions about the purpose of QUAC and community health generally to a review of the services and programs provided from that centre and finally to a consideration of the centre's objectives and their evaluation in terms of key performance areas, indicators and measures, as defined above.

The next stage was for the Project staff to review the key performance areas, indicators and measures which had been defined in each of the workshops and to draft a common set of areas, indicators and measures which encompassed those defined for the individual centres during the workshops.

It was originally intended that this draft set of performance areas, indicators and measures would then be trialled in the pilot centres. The Health Service Agreements Program supervened and this next trialling stage has not taken place. Nevertheless, the draft evaluation framework presented in the Interim Report has been used as the basis for negotiating community health agreements.

7.4 Outcomes

Perhaps the most valuable 'outcome' of the Project was the boost to discussion and thinking within the community health field in Victoria about evaluation and related issues which flowed from the workshops and the publication of the Interim Report. The evaluation of the workshops revealed a renewed awareness and energy in relation to these issues among CHC staff and committee of management members taking part.

The workshops highlighted a range of issues faced within community health, although not all of these were addressed by the Project.

An explicit outcome of the Project was a set of suggestions for continuing this process of discussion and some structural recommendations designed to help to meet some of the needs which were identified during the course of the workshops.

The formal and planned outcome of the Project was the draft evaluation framework comprising key performance areas, indicators and measures drawn from the suggestions from the individual workshops by the project staff.

Two **general areas of health centre performance** were identified:

1. Service and program performance (what CHCs offer to the community), and

2. Organisational performance (how CHCs operate).

The Key **Performance Areas** recognised within these general areas were:

Services and Programs Areas:

- primary health care
- individual health promotion
- community development

Organisational Performance Areas:

- community participation and
- community accountability
- management.

The Key **Performance Indicators** defined in relation to each of these areas were as shown below (taken from Table 1 in the Interim Report).

Performance Measures were suggested for each of the Indicators identified as relevant for each of the Performance Areas. The following are the performance measures which were identified as needing to be followed **at the level of the CHC** itself.

Community Development

Accessibility:

- number of participants/number in target group,

Appropriateness:

- centre priorities,
- types of centre programs or activities
- % of centre resources allocated to CD,

TABLE 1

	Service and Program Areas			Organisational Areas	
	Community Develop't	**Individual Health Prom'n**	**Primary Health Care**	**Community Participation Accountability**	**Managment**
Accessibility	•	•	•		
Appropriateness	--				•
Community Partlcip'n	•				
Effectiveness	•	•	•	•	•
Efficiency		•	•	•	
Availability		•	•		
Quality		•			•
Utili<,ation			--		

Community Participation:
- number of community members involved in planning, implementing and maintaining programs/activities,

Effectiveness:
- evaluate trends over time (behaviours, health status, environmental changes),
- number of self-reliant groups operating independent of the centre.

Individual Health Promotion

Accessibility:
- no. of participants/no. in target group,
- hours/times,
- venues,
- languages,
- child care,
- transport,

Effectiveness:
- evaluate trends over time by health status/health behaviours,

Efficiency:
- % of staff time spent in these activities,
- % of centre resources devoted to these activities,
- cost of services,

Availability:
- no. of programs and types,
- no. of staff and types,
- no. and types of printed information,

Quality:
- peer review,
- accreditation measures.

Primary **Health Care**

Accessibility:
- venues,
- times,
- language,
- sex of provider when appropriate,
- child care,

Utilisation:
- no. of clients by reason and health problem,

Effectiveness:
- evaluate by specific intervention/outcomes,

Efficiency:
- no. of people referred to other staff within health centre,
- no. of people referred to resources outside of the health centre,

Availability:
- numbers and types of services,
- no.sand types of staff.

Community Participation and Community Accountability

Effectiveness:
- committee of management (COM) elected by local community,
- COM representative of local community,
- numbers attending centre meetings committees,
- COM subcommittees for policy, development, service and program development and evaluation,

Efficiency:
- COM reports, minutes available to community,
- COM appropriate resource allocations,
- subcommittees (of COM) open to community.

Management

Effectiveness:
- process for prioritising staff resources,
- utilisation/participation rates reviewed regularly,
- data collection system reports regularly,
- periodic review of all activities, priorities,

Efficiency:
- regular reports on nos utilising services/programs,
- regular financial reports,

Appropriateness:
- objectives met for priorities set,
- consumers' satisfaction with services/programs,

Quality Assurance:
- standards for quality assurances set and reviewed regularly,
- peer review.

A more limited set of **performance measures** were suggested **for inclusion in reports from centres to the Health Department,** centrally. (The Project did not consider reporting at the regional level.) The proposed data set for reporting centrally is as follows.

Community Development
- types of programs,
- % of centre resources allocated to community development
- no of participants in CD activities,
- no of community members involved in planning activities.

Individual Health Promotion
- type of individual health promotion programs and activities,
- % of centre resources allocated to individual health promotion programs and activities,
- number of participants.

Primary **Health Care**
- % of centres with salaried GPs
- types and numbers of other health care services,
- types and numbers of other allied health providers,
- numbers of individual clients,

– number of individual contacts.

Community Participation and Accountability

- elected COM,
- annual report,

Management

- audited reports,
- numbers utilising services and programs.

7.5 Comment

The Interim Report of the QUAC Project is an important document for community health. It has some important strengths. However, the Project was based fundamentally on a set of assumptions which in some respects maybe inconsistent with a community development approach to community health. The Report is important for its strengths but also because of its dangers.

Strengths

The QUAC project was implemented in close partnership with the pilot centres. The emphasis on workshopping the issues locally encouraged a sense of ownership on the part of the CHCs with respect to the outcomes of the process. In this sense it was developmental rather than imposed. On the other hand the actual design of the Project and some of the key concepts built into it appear to have been more top down.

The six CHCs who participated in the QUAC workshops found them valuable although time consuming.

By clarifying their aims and objectives, the process helped them to review the role and direction of their centres.

Communication among staff and between staff and management, was enhanced.

It increased their understanding of community health concepts and helped to strengthen consensus within each centre.

It helped them to review and clarify their work roles, and to determine performance in identified areas.

Another important strength of the QUAC Project is the Interim Report itself. In its discussion of the tasks of community health the narrative is particularly insightful and it should remain a key reference document in community health for quite a while. The workshops approach and their results should be of continuing interest to other community health services.

Concerns

Whilst the foreshadowed stages 3 and 4 have not proceeded, the results of the Project have, at least in part, been used in the development of the standard framework for Community Health Agreements.

The QUAC Report is an important document for community health nationally because of the growing emphasis on output-oriented corporate rationalism in health service administration in Australia. There has been increasing pressure, not just in Victoria, to apply this 'managerialist' approach to community health. The QUAC Project took some of the key elements of the this philosophy and sought to apply them in community health settings. The outcomes of the Project (in particular the key performance areas, indicators and measures) demonstrate the limits and perhaps the dangers of this philosophy in community health.

It is unfortunate that more care was not given to the language used in the definitions on which the QUAC evaluation framework is based. The key performance indicators so-called would have been better defined as dimensions or aspects. They are not indicators. The term indicators would have been better kept to describe the so-called performance measures.

The concept of indicators is itself problematic. It is a common experience that indicators which might have been originally presented as complementing a broad descriptive understanding of work being undertaken in CHCs can get taken out of context when the functions of evaluation (for learning and planning purposes) become confused with reporting (for accountability purposes). The distortions arc exacerbated when the performance objectives developed for particular projects and programs are collapsed and aggregated for reporting to Government. In such circumstances the indicators come to be used as control variables for determining resources or benchmarks for judging performance rather than indicators of a more complex concept such as the development in coherence and strength of an identified group or network or community.

The conceptualisation of 'evaluation' within QUAC is also seriously limited in that it does not address explicitly the issue of values in evaluation. Evaluation is the application of a set of values to the phenomenon being considered. Widely differing values with respect to assumptions and priorities in community health are an important feature of the environment within which this evaluation framework is to be used. The adoption of different approaches to planning and evaluation may have different implications in relation to control and accountability.

The pressure to adopt a management by objectives approach in community health and the demand for accountability reports structured around quantitative performance indicators is part of the ascendancy of the corporate rationalists in health service administration. This approach is clearly suited to the demands being felt at senior levels of health planning and administration. It might in fact not be the approach best suited to the planning and evaluation of services and projects in community health at the level of the local community health centre level.

The focus on outcomes which is part of management by objectives is inappropriate in relation to both clinical services and community development work. In both cases, the process, the way the transaction is undertaken, is just as important as the outcome, however defined.

8. HEALTH SERVICE AGREEMENTSos)

8.1 Background

The Health Service Agreements Program was introduced into the Victorian health field from 1985.

Health Service Agreements (HSAs) are documents which set out the operating arrangements between a health service agency (eg hospitals, psychiatric facilities, community health centres) and the Health Department of Victoria. Community Health Agreements are HSAs with community health centres. At the time of writing (late 1988) 12 Victorian CHCs were operating in accordance with a formal agreement and at least a score of others are close to finalising agreements.

The Department presents agreements as a radical departure from the traditional management approach which emphasised control of **inputs** (cg line by line budget negotiations and controlled staff profiles) in the relationship between government and health agencies towards a focus on **outputs** and performance in the delivery of services. It is argued that 1-ISAs will have the effect of:

- directing the focus of agency management to the achievement of agreed goals and targets,

– improve the accountability of the Health Department and the health service providers for the use of public funds,

-establish a more sound management relationship between health service agencies and the Health Department, including the delegation of greater management responsibility to the health agencies themselves and a reduction in non-strategic reporting requirements.

The Department has identified three principles as being crucial to the agreements process. These are:

1. **Participation.** The agreements process is designed to encourage the participation of all the interested parties (within and outside the service agency) in helping to develop objectives and strategies, goals and targets. Participation should occur at every step, especially between the agency and the Health Department to ensure it is an open process.

2. **Responsibility.** Controls imposed on health service agencies by the Health Department have accumulated over many years. The Department expects that with negotiated agreements red tape will be diminished and greater authority will be devolved to the health agencies.

3. **Accountability"** Agencies must be accountable to the Health Department and to their local community for the services they provide, not merely for the resources they use. The Department expects that health service agreements will enhance this accountability, firstly, because by shifting the emphasis from monitoring inputs and resource control to more output-related measures reporting is made more meaningful and secondly because the agreements themselves are public documents, so there is opportunity for real public scrutiny.

Some caution needs to be exercised in interpreting this account of health service agreements because the field is moving fast and becoming increasingly divergent. Different practices and different understandings of the agreements program are evident between the different Health Department regions and between different centres.

8.2 The Process Of Establishing Community Health Agreements

The Department emphasises that agreements are to be flexible in content. However, there is a standard format for all agencies which includes the following core components:

- the context in which services are provided, including historical, demographic and environmental factors, regional and state health plans as well as local perspectives;

- key priority functions, including the specification of service objectives and goals;

- an operational plan for the agreement period outlining the services and targets to be achieved in return for specific resources;

– resources to be provided by the Health Department;

- reporting requirements.

The negotiating process.

The Department has outlined the several phases of the negotiating process prior to the signing of a first agreement, to be completed over a six month period.

1. Preliminary discussions in the CIIC. The CHC:

– conducts broad based discussions with all staff and local community representatives re current and potential services;

- determines a broad strategic position (with respect to role and function) in consultation with Health Department Regional Office;

– assesses other contextual factors (as listed above);

- determines timclines and key events in the negotiating process with the Regional Office;

- determines how formal and informal communications between CHC and the Regional Office will be conducted;

- develops an awareness of the agreements process and key tasks amongst staff and stakeholders.

2. Training workshops, provided by the Health Department with a view to developing the 'necessary skills and commitment among key stafr.

3. CHC to develop initial draft agreement.

4. Draft agreement submitted to the Regional Office.

5. Negotiating sessions, an iterative process during which it is hoped the draft agreement will be refined, amended and agreed upon.

6. Health Service Agreement is signed by the Committee of Management and the Regional Director of Health.

The negotiation of second and subsequent agreements commences with the evaluation of the previous years result, then agreement on the negotiation procedures and then into the discussion of priorities.

Performance Measures.

The development of acceptable and accurate performance measures is a crucial part of the agreements process. The guidelines stipulate that performance indicators should be derived from agreed goals and targets (and not vice versa) and should be both feasible to measure and a reliable and valid way of assessing actual achievement. Indicators should:

-actually measure or accurately represent the target that was established,

--cover both volume and quantity of achievement,

-set the time within which outputs are to be achieved.

8.3 Commentary

The above account encapsulates the official Health Department view of I-!SAs. However for the community health centres involved in the first round of agreements negotiations the reality was somewhat different.

CHCs generally supported the basic principles underlying the agreements process with its commitment to negotiations and consensus. They found that the process encouraged staff and committees of management to examine their basic philosophy, their aims and goals, and their own roles in relation to community needs.

However, many community health centres encountered serious difficulties in negotiating their agreements with the Health Department.C39) These problems can be summarised as follows.

-- Unrealistic timelines. Too much was expected in too short a time and the time frame did not tic in with State and regional budgeting making it very difficult to plan for resource allocation.

-- The Health Department has not kept to its own timetable with respect to the preparation of regional plans. Agreements regarding the role of individual health centres have been negotiated in the absence of any broader planning guidelines about the development of services to that region.

-- The agreements proforma was too rigid. It was couched in a jargon that was not owned by the CI-!Cs and their communities and was seen as imposed from above. The proforma was based largely on a hospital model and was not suitable for community health. Too much detail was required.

- The training package for the workshops was based on a particular managerial philosophy and was inappropriate in many respects. The sessions were held at times which precluded most committee of management members from attending.

- There was confusion between the roles of central office of the Health Department and the Regional Office. Each gave conOicting directives to the CI-!Cs.

- A major difficulty was experienced in trying to develop 'qualitative performance measures' and '.effectiveness indicators'. Most community health work (especially health promotion and community development) does not easily lend itself to a 'goals, targets and indicators' approach.(40)

- CHC staff (having more information and being more accessible than the committee of management) were pushed into a role of 'deciding' on behalf of their committees of management. CI-!C staff and management feel that this is a wrong process that effectively decreases the power and autonomy of committees of management.

- Many CI-!Cs did not own their agreement because they did not feel equal partners and did not gain the increased autonomy they had been offered.

"The Department has a long way to go in terms of understanding how community health works. The process needs to be two way, but the power of the party with the purse strings is more than the power of often fragile and disparate members of committees of managemenr. ii(41)

Some of the problems noted here arc to be expected in a pilot process but others are more fundamental. They reflect the inherent contradictions involved in trying to marry a top-down 'corporate management' approach to the developmental, community oriented philosophies espoused by community health centres.

(1) Community Development in Health. 2 Planning, Evaluation, Research and Accountability. See Section 2 of this Resources Collection. Referred to hereafter in these references as CDIH Paper #2 (Planning and Evaluation)

(2) Kensington Community Health Centre, 12 Gower St., Kensington, Victoria, 3031. Telephone: (03) 376 0523.

(3) CDIH Paper #2 (Planning and Evaluation). Op cit.

(4) Fitzroy Community Health Centre, 75 Brunswick St., Fit2roy, Victoria, 3065. Telephone: (03) 419 5266.

(5) A more detailed account of the history of the Fitzroy CHC is included in 'The Community Development in Health Continuum' by TJackson, S Mitchell and M Wright, presented first at the 1988 ACHA Conference in Melbourne and subsequently submitted for publication in Community Health Studies. See Section 6 of this Resources Collection.

(6) Two others which we are aware of are Southport and Eaglehawk CHCs, in addition to Kensington.

(7) Community Development in Health: 1. Health and illness in a social context and the role of community development. See Section 1 of this Resources Collection. Referred to hereafter in these references as CDIII Paper#1(Overview Paper)

(8) CDIH Paper #2 (Planning and Evaluation). Op cit.

(9) Why Women's Health (1986). The Report of the Victorian Women's Health Working Party. Available from the Victorian Government Information Centre, 318 Little Bourke St., Melbourne, 3000. Telephone: (03) 651 3033.

(10) 'Our Health Our Hospital. Victorian Women Talk With the Royal Women's' Hospital. Report of the 1988 Community Consultation. Available from the Public Relations Department, Royal Women's Hospital, Grattan St., Carlton, Victoria, 3053. Telephone: (03) 344 2000.

(11) Further information about the DHC Program is available from the Coordinator, Health Department Victoria, Box 4057, GPO, Melbourne, 3001. Telephone: (03) 616 7601.

(12) Further information from the Social Health Branch, South Australian Health Commission, Pirie St., Adelaide, 5000. Telephone: (08) 218 3211

(13) See particularly Section 7 of CDIH Paper#1(Overview Paper). See also Section 3.2 of CDI!-1 Paper#2 (Planning and Evaluation).

(14) "Let's Hear If From Women". Report of 1987 Lcongatha Women's' Health Day. Copies may be available from the Strzelecki DHC, c/o PO Box 401, Leongatha, Victoria, 3953. Telephone: (056) 62 3565, (051) 33 9433.

(15) Report of the Wirnmera Women's Health Day. Copies may be available from the Wimmera DHC, PO Box 73, Horsham, Victoria, 3400. Telephone: (053) 82 5488.

(16) "Exploring the Hospice Concept". Report of the Strzelecki Palliative Care Project. Copies may be available from the Strzelecki DHC, c/o PO Box 401, Leongatha, Victoria, 3953. Telephone: (056) 62 3565, (051) 33 9433.

(17) "Two Different People in One Day." A study of health issues affecting young people of non-English speaking backgrounds. R Castania and J Maddison. A joint project of the Preston Northcote DHC and the Victorian Youth Policies Development Council. Contact Preston Northcote DHC, PO Box 57, Northcote, Victoria, 3070. Telephone: (03) 481 7761.

(18) 'A Stitch in Time'. Report of the Women's Health Research Project. Available through the Loddon Dl!C, PO Box 927, Bendigo, Victoria, 3550. Telephone: (054) 42 1044.

(19) Aged Care Services Project, 1987. Contact Wodonga and District Health Council, PO Box 982, Wodonga, 3690. Telephone: (060) 24 2054.

(20) See the discussion of strategic planning in Section 2 of CDIH Paper#2 (Planning and Evaluation). Op cit.

(21) Contact DJICs direct for copies of current Strategy Plans.

(22) The Precede model is discussed in "Health Education Planning - A Diagnostic Approach" LW Green ct al (1980). Mayfield Publishing, Palo Alto, California.

(23) See Section 5.2 of CDJH Paper #1 (Overview Paper). Op cit.

(24) An Assessment of the PATCJ-I Program. Report to ACHA by Denise Fry following the PATCH Workshop at Wcstmead Hospital, 31 August to 3 September 1987.

(25) Fry D and U Brockoff (1983) First Steps Toward Community Health Accreditation. Australian Clinical Review, December 1983, 19-21.

(26) A Manual of Standards for Community Health. Published by the Australian Government Publishing Service for the Sydney University School of Public Health and Tropical Medicine. Available from AG PS.

(27) It is worth noting the very different meanings given to the word "indicators" within CHASP as compared to QUAC.

(28) Fry D and L King (1986) Standards of Community Health: The National Community Health Accreditation and Standards Project. Community Health Studies, Vol X, 3.

(29) First announced in Community Health Centres: A New Focus. Policy Statement released by the Health Department Victoria, May 1987.

(30) Area Health Services. Supplement to Accreditation Guide. Australian Council on Hospital Standards (1988).

(31) 'Systems of Standards for Community Health. A Progress Report on Implementing CHASP Across Australia'. D Fry and D Neverauskas, in Proceedings of 2nd National Conference on Community Health. Melbourne, May 1988.

(32) This account of the QUAC Project comes mainly from the Interim Report of the Community Health Quality, Utilisation, Accountability and Cost Project. Health Department, Victoria, November, 1986.

(33) "A Community Health Program For Australia." Report from the National Hospitals and Health Services Commission (Interim Committee). AGPS, Canberra, 1973.

(34) Report of Ministerial Review of Community Health. Health Department, Victoria, 1985.

(35) From here on the abbreviation CHCs should be taken to encompass community health services, some of which arc not organised as identified centres.

(36) It is worth noting the very different meanings given to the word "indicators" within CHASP as compared to QUAC.

(37) This description of the rationale and framework of the Health Service Agreements Program is based on the Health Department's information package. Available from The Manager, Health Service Agreements Program, Health Department Victoria, PO Box 4057 GPO Melbourne, 3001.

(38) 'Evaluation of the Pilot Community Health Agreements Process'. Katherine Wositzky. Health Issues Centre. March 1988.

(39) 'Those who don't learn from history are bound to repeat it's mistakes'. Workshop paper presented by Bill Deveney and others to the 2nd ACHA Conference in Melbourne, April 1988.

(40) For a critical discussion of the application of outcome focussed reporting in health work see COii! Paper #2 (Planning and Evaluation) at Section 2 of this Resources Collection. In particular the following passage (modified slightly from Section 3.2):

"In fact, it is not meaningful to evaluate community development work purely in terms of 'outcome indicators'. Demands from government and other funding bodies to 'evaluate your work' in terms of 'ultimate outcomes' may rcfkct a lack of understanding about community development work; it may be an allcmpt to curb and constrain that work; it may be both.

"It is interesting to note that these pressures to demonstrate outcomes are not applied in the same way to clinical medicine. There is no pressure to report hospital performance in terms of improved health outcomes although there is pressure on clinicians to participate in quality assurance; to demonstrate that they are (undertaking and) evaluating their work in (accordance with) the best current understandings of medical science and that they arc criticising and contributing to the development of those understandings.

"These expectations set a precedent that that might reasonably be required of community development workers in health ... "

(41) See Deveney et al. Op cit.

FINAL ASSESSMENT FORM

Project Title: _____

Date: _____

1. Give your assessment of the extent to which the program has achieved its specified objectives with the chosen target group? On what do you base this assessment?

2. Note any ways in which the implementation of the program has differed significantly from what was planned and why this has occurred.

3. Note any significant unexpected outcomes of the program and why they occurred.

4. Who do you think benefitted from the program and in what ways? (If nobody, say so)

5. Estimate the time (total number of work hours) staff members spent on this program in:

Planning and preparation: _____

Implementation: _____

Follow-up and evaluation: _____

6. Is there a need for any long-term follow-up/evaluation of this program? If yes, describe what is needed. If no, explain why.

KENSINGTON COMMUNITY HEALTH CENTRE - COMMUNITY WORK - PINK PROPOSAL FORM

PROJECT TITLE:

WORKERS:

DATE:

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1. Have you discussed this proposal with other staff? YES NO

2. Did you use the guide to help you fill this out? YES NO

3. Give a brief description of the project in only a few lines of the project including its target group. It might be easier to fill this in last of all.

4. Describe which needs you are trying to address and provide any relevant background?

5. Describe how this project will try to tackle those needs?

6. Is this project a planned part of a wider strategy for one of this year's priorities? If not, how does it fit in with those priorities?

7. Give some justification for us doing this project now (given our centre's philosophy, our capacities, chances of success, skills and priorities, especially if you answered no to question 6.

8. What is the view of other relevant community groups/agencies about this project?

10. What is the expected timetable for the project?

11. Describe your role(s) in the project?

12. How much worker time will be required, as well as any other resources?

13. How much community work time do you get per week? What other projects are you involved with, and which may you have to cut back, in order for you to work on this project?

14. When will project be monitored next, and how will you elicit participants' views on its outcomes?

15. Any other comments.

N.B. Have you filled in Question 3?

any of the priorities, if at all?

07. In choosing annual priorities, we are attempting to focus our activity and effort. New projects, therefore, that fall outside those priorities, need to be better justified than those that, in effect, have been previously agreed to as part of a strategy.

Programs generally should be justified on the basis firstly that it can be shown that the issues with which they're concerned are important, (i.e., need attention) and thus should have high priority in the work of the staff concerned. Secondly, the actions proposed should be shown to be both feasible and useful. Overall these grounds form the justification or rationale of your program. If it is not possible to support the program on all these grounds, it is worth reconsidering whether you should be doing it at all. Perhaps a different approach is required or another area of need should be considered.

08. Consulting with local agencies and community groups ensures that your program will not duplicate or conflict with other projects being run in Kensington or the subregion, and maintains good relationships amongst related groups. It provides feedback on your perceptions of the need for a project and its feasibility.

09. Use as many sheets as required to detail your aims, goals and tasks.

Aims are general statements of what we intend to do. They can be the vision for your project and may well be impossible (e.g. provide free dental care for all residents of Kensington, enable all residents to have a say in K.C.H.C. decision-making, inform all residents about AIDS etc.). You may have several aims. You should always include an **empowering** aim wherever possible. This will describe what your project hopes to achieve in enabling local residents to have more control over their lives or the community's affairs (e.g. to maximise local residents influence in affecting Health Department policy, or to enable group members to take control of the group, or to maximise passing on of skills etc.).

For each aim, detail all the goals i.e. the steps you need to take to reach the aim. A goal is specific, achievable and measurable. It leaves little doubt about what is to be done and the result intended.
For example,

- write a submission for a local community controlled dental service, by September.'
- publicise the beginning of a chronic back-pain support group by July 1st.'
- attend at least 75% of the meetings of the District Health Council and appropriate sub-committees until November.'

For each goal, outline the main tasks to be done. They should be concrete, clearly defined and measurable, e.g.

- ring 5 other dental services about their cost structure;
- design a poster and distribute to all local meeting places, milk bars in Kensington.

Example

Aim	Goal	Tasks
Reach the stars	build a rocket	manufacture panels tighten nuts etc
	train pilots	select pilots design training prog.
	chart a course	choose destination

010. Give details of the beginning and end of the project, or estimated times for parts of it (if not already specified in goals). How will you know if the project ceases to be viable and what will you do then?

011. Outline your role. This is generally different from many of the aims of the project but should link in with the empowering aim. For example (the main aim might be to inform the community about AIDS, but your role might be to organise the campaign or to facilitate a group of high risk residents to organise the campaign itself).

012. Detail any budget, room space, equipment you will need, as well as the key resource - your time.

013. New programs inevitably entail trade-offs of existing services or programs. Note here which activities can be cut back or reallocated to allow you (and your co-worker) to be involved in this project. Include evidence that you have discussed reallocation of work loads with co-workers who would be affected.

014. We want to encourage workers to get more feedback from participants on what benefits they have got from their involvement. Perhaps it would be useful to start thinking of that now, as you might need to gauge people's current situation first to use as a comparison later on.

015. These questions aren't perfect. Add anything else that seems relevant.

PLEASE LET MARTIN OR TONY KNOW YOUR REACTION TO THESE FORMS AS A GUIDE TO PLANNING YOUR PROJECT. WE REALISE THAT THE FORM AND GUIDE MAY BOTH NEED SOME CHANGES UNTIL STAFF AND BOARD ARE HAPPY WITH THEM.

KENSINGTON COMMUNITY HEALTH CENTRE - COMMUNITY WORK - MAUVE MONITORING SHEET

PROJECT TITLE:

WORKERS INVOLVED:

DATE OF LAST REVIEW/PROPOSAL

DATE OF THIS REVIEW:

1. Attach a photocopy of the Aims, Goals and Tasks sheet from the Planning form and update what has been achieved or changed.

2. Describe how the project is going ,including any major changes or developments in the project?

3. What are participants getting out of the project and have you had any feedback about the project from them or the community? How have you found this out?

4. If your project is not part of one of this year's priorities, give some justification for us continuing to support it.

5. Comment on your role in the project so far. Should it ?

6. Comment on the use of resources for the project so far.

7. What is the current timetable for achieving goals and tasks for the project?

8. Other Comments.(Note: eg. you may wish to comment on any lessons you may have learnt from your involvement in this project so far).

9. Next Review Date:

10. Summary:

KENSINGTON COMMUNITY HEALTH CENTRE - GUIDE TO MAUVE MONITORING SHEET

Q1.
This will help others (and yourself) see where you are up to in your project. If you have achieved any of the tasks or goals then a tick next to those entries will be sufficient. Cross out any aims, goals or tasks which are no longer applicable and add any new ones.
If your aims have changed significantly it would probably be better to write out a new pink planning sheet.

Q2.
Summarise the progress, for examaple how you are going with your aims, goals and tasks as outlined last time. Describe any major developments or changes in relation to:

(i) Overall direction or orientation.
(ii) Target group.
(iii) Staff/community members involved in project.
(iv) Reaction by other community groups etc.
(v) Resources.

What action have you taken or are you going to take, to respond to these developments? Is this still consistent with the philosophy and priorities of K.C.H.C.?

Q3. You could get this feedback from participants by:

(a) Asking residents.
(b) Group discussion.
(c) Questionnaire.
(d) Getting another person to speak to the group.
(e) Your own innovative method.

(For internal or liaison projects this question is probably not applicable). Relate this feedback to your empowering aim(s) as detailed in your last proposal/monitoring sheet. For more details on empowering aims, see guide for pink proposal sheets.

Q4.
Is this issue still important and is the project still feasible and useful?

Q5.
Take a critical look at your effectiveness or usefulness in this project. You may wish to compare your current role with the role that you described in the planning sheet. What changes in your role have occurred? Should you amend your role now (eg should you be taking more of a back seat role)?

Q6.
Resources include equipment, money and staff. Have the resource needs for the project remained the same? How much staff time has been spent in the project so far? How much time would you or other staff members be spending on the project at the moment (i.e. average number of hours per week?

Q7.
You only need to summarise or give a rough guide to timetable for main goals and tasks.

08.
Add anything relevant you have not said already. For example you might have learnt some lessons from your recent work that would be useful to share.

09.
When do you think this project should be monitored next?

010.
In 5 lines or so, try to sum up the project's progress and current situation. This might be similar to the answer you would give if passing a board or staff member in the street and being asked "how's your community work project going?" For example, without going into any details, you might answer that the project is going well, reasonably according to plan, but that your role has changed because the target group is slightly different. You might also comment on the likely success of the aims of the project.