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Adding value through community participation: evaluating capacity in community health committees

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This article describes the procedure involved in evaluating the effectiveness of the capacity-building process within the Community Health Committees (CHCs) established by the Sunrise Health Service Aboriginal Corporation (SHSAC) as part of their service governance structure. SHSAC itself was set up as the initial stage of the rollout of the Katherine East Coordinated Care Trial in the Northern Territory. A purposive sample of three CHCs was selected in consultation with SHSAC for the evaluation.

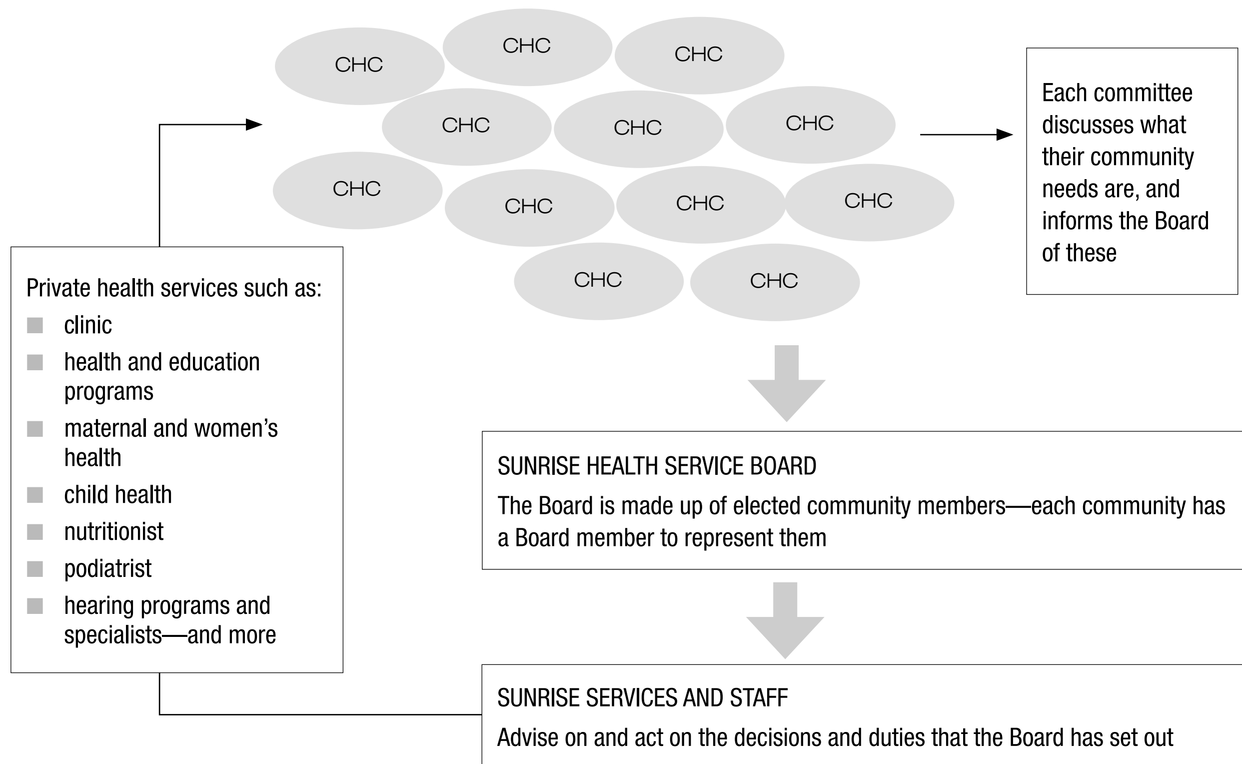
The development of an evaluation instrument and the subsequent evaluation of the capacity of the health committees was one part of the overall evaluation of the Katherine East Coordinated Care Trial. The criteria for measuring capacity were developed in close collaboration with members of the CHCs and the SHSAC Community Development Unit. The evaluation framework was based on the Community Capacity Index (Bush, Dower & Mutch 2002), which assesses four areas of competence. This framework was suitably modified in collaboration with the Community Development Unit to reflect the Sunrise Health Service situation. The result was an evaluation that increased knowledge and capacity for the CHCs and Community Development Unit, in addition to evaluating the capacity of the CHCs to function in their designated role.

Background

Community health committees were formed during the setting up of the Sunrise Health Service Aboriginal Corporation (SHSAC) as part of the service governance structure. The health service itself was instigated as the initial stage of the rollout of the Katherine East Coordinated Care Trial, one of five that comprised the Second Round Coordinated Care Trials.

This particular Coordinated Care Trial was located in the Katherine region of the Northern Territory, 312 kilometres south of Darwin. The area covered by the Katherine East Coordinated Care Trial was approximately 75 000 square kilometres and included nine communities and associated outstations. The trial targeted the whole population of these communities including the predominant Aboriginal population, as well as non-Aborigines in the area and those on pastoral leases. The estimated population of interest was 3700.

FIGURE 1: THE STRUCTURE OF THE SUNRISE HEALTH SERVICE ABORIGINAL CORPORATION (SHSAC)



Source: SHSAC

SHSAC is based on a model of comprehensive primary health care as originally formulated in the Declaration of Alma Ata (WHO 1978) and which has been used successfully by Aboriginal Community Controlled Health Services (ACCHSs) in Australia over the past 30 years (Wakerman et al. 2007, p. 13). The structure of the service is depicted in Figure 1 and consists essentially of four parts: the community health committees, the Board, the health service executive committee and the service delivery section.

The CHCs are elected by their respective communities. These committees discuss health needs with their communities and pass this information onto the Board. The Board then reviews this information and relays decisions and advice to the Executive, which actions the decisions via the Service Delivery Unit.

Evaluation framework

While the main objective of this evaluation was to assess the change in capacity of the CHCs over the period of the trial, equally important from the perspective of SHSAC was the involvement of the CHCs in the evaluation process in order to strengthen their capacity.

Capacity building through community development is central to the comprehensive primary health care model and is arguably the most difficult approach. Crisp, Swerissen and Duckett (2000) describe four approaches to capacity building: the bottom up organisational approach, the top-down organisational approach, partnerships, and the community organising approach. The latter is described as the most ambitious approach to capacity building and involves working with communities, particularly the most disadvantaged, to solve their health-related issues (Crisp, Swerissen & Duckett 2000, p. 102).

Meanwhile, The Ottawa Charter for Health Promotion, articulates a comprehensive primary health care strategy, stating:

> Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support. (WHO 1986)

For SHSAC the strategy for implementing this approach was to build capacity in the CHCs to interface with their respective communities better. In developing the evaluation framework one of the fundamental questions posed was: *How can the CHCs get the most value from the evaluation?* Initial discussions with the SHSAC Community Development Unit indicated that this could be achieved by helping communities to understand the evaluation process, by involving them in

the evaluation design, and by allowing ongoing participation and feedback.

Consequently, a framework for evaluating the CHCs' capacity was developed in consultation with members of the committees and the Community Development Unit. The framework was based on the Community Capacity Index (Bush, Dower & Mutch 2002)—an abbreviated version of which is shown in Table 1. This framework was then suitably modified to reflect the Sunrise Health Service situation and allow involvement of the CHCs in developing appropriate indicators. Within the framework (Table 1) there are four domains of capacity, namely the ability to:

- form networks and partnerships in the community
- communicate knowledge and information between groups in the community
- solve problems and obtain support to solve problems
- form and maintain a formal structure to deal with health issues in the community (infrastructure).

Within each domain there are three ascending levels of competence for each of the first three domains mentioned, while the last domain is divided into four sub-domains of sustainability.

In the original table for each level of competence, a number of statements/questions are provided which are scored on a four-point Likert-scale. The scale ranges from *not at all/very limited* through to *almost entirely/entirely* . The answers to the questions are aggregated to give an overall score for each level. (For a complete description of this process see Bush, Dower & Mutch 2002.)

After discussion with the Community Development Unit, it was decided that this process was overly complex to be used with the CHCs and did not provide enough involvement from them.

Therefore, a simpler format was developed. The questions/statements together with their associated Likert scale provided in each level-of-competence box were to be discarded in favour of an overall statement of competence. This statement would still retain the sense of the original framework, but would allow the CHCs input to refine this statement and develop their own indicators. The infrastructure column underwent the most modification in that the four sub-domains of sustainability would be discarded and the final column would only reflect the capacity of the CHCs to run CHC meetings effectively. This would be the sole concept of infrastructure for this exercise. Once the committees could organise and hold meetings without Community Development Unit support they would be deemed sustainable. Therefore, column four would have three levels of capacity in line with the first three. Table 2 shows the revised framework.

The domains of sustainability were replaced by one infrastructure column with three levels of competence in line with the other three columns. The infrastructure now referred to the organisational infrastructure of the committee and reflected their ability ultimately to organise and run meetings without the support of the Community Development Unit.

This framework formed the basis of the evaluation framework that was developed with the CHCs. The concepts of network partnerships, knowledge transfer, problem-solving, and

TABLE 1: A FRAMEWORK FOR EVALUATING A COMMUNITY HEALTH COMMITTEE'S CAPACITY

(based on the Community Capacity Index (Bush, Dower & Mutch 2002)

<table>
<tr><th>Network partnerships</th><th>Knowledge transfer</th><th>Problem-solving</th><th>Infrastructure (sustainability of the infrastructure)</th></tr>
<tr><td colspan="3">Levels of capacity</td><td>Sub-domains of sustainability</td></tr>
<tr><td>Level 1
Identify resources</td><td>Level 1
Develop a program meeting local needs</td><td>Level 1
Work together to solve problems</td><td rowspan="3">Policy investments
Develop program-related policy
Financial investments
Develop financial capital
Human/intellectual investments
Develop human/intellectual capital
Social investments
Develop social capital</td></tr>
<tr><td>Level 2
Deliver a program</td><td>Level 2
Transfer knowledge to achieve desired outcomes</td><td>Level 2
Identify and overcome problems</td></tr>
<tr><td>Level 3
Maintain a program</td><td>Level 3
Integrate a program into mainstream practices</td><td>Level 3
Sustain flexible problem-solving</td></tr>
</table>

TABLE 2: THE REVISED FRAMEWORK FOR EVALUATING A COMMUNITY HEALTH COMMITTEE'S CAPACITY

Network partnerships	Knowledge transfer	Problem-solving	Infrastructure
Levels of capacity			
Level 1 Identify key community players and develop links	**Level 1** Engage community groups	**Level 1** Identify and discuss relevant issues	**Level 1** Call and run meetings with Community Development Unit support—low community integration
Level 2 Links developed with key community players	**Level 2** Transfer knowledge	**Level 2** Instigate mechanisms for problem-solving	**Level 2** Call and run meetings with Community Development Unit support—medium to high community integration
Level 3 Sustain working links with key community players	**Level 3** Process knowledge and provide feedback	**Level 3** Sustain problem-solving framework	**Level 3** Call and run meetings without Community Development Unit support. High community integration

infrastructure in the context of the CHCs was mapped out with the Community Development Unit and then discussed with the CHCs. Each domain of capacity and level of competence was examined in order to develop a statement of ability. Once agreed on, this information was tabulated (Table 3).

From these statements of capacity, a number of questions were developed for each of the levels in each of the domains and reproduced as open-ended questionnaires. Two sets of questionnaires were developed. One was to be directed to the CHCs, while the other was to reflect the views of other sectors of the community which would be determined as part of the evaluation.

For example, in the 'Network partnerships' column the first level of competence to form a network partnership aims to identify and communicate with the different community factions. The statement reads:

> CHC has the ability to define groups (clans and power factions) within the community and initiate communication with them. Therefore we ask CHC the question: *Who are the different clans and power factions within the community and are you talking to them all?*

Answering this question effectively produces a social mapping of the community. Meanwhile it indicates to the evaluator whether the CHC is aware of all the community stakeholders with which it needs to develop networks. At the same time, it makes the evaluator aware about which sectors (or individuals) of the community need to be targeted for questions. If the answer to this section is covered adequately, then the first level is reached in that column. Then we move to Level 2 and ask the question: *Has this ability to build networks been taken further (from the evidence of the level of community recognition)?*

This is achieved when the CHC is recognised by the community as a legitimate conduit for health issues discussion. Here we ask the CHC the question: *Do all clans in the community recognise you as a voice for their health concerns and talk to you when approached?* If the answer is 'Yes', the CHC has built the start of a working network recognised by the community and Level 2 in the framework is reached. The answers given by the CHC are then corroborated with the answer given by the other community sectors identified previously.

Finally, we reach Level 3 and want to know if the CHC has the ability to maintain the network between community groups and we ask the CHC:

> Are you talking to all clans and groups in the community and do they come to you to discuss issues? And: Do all the groups respect you as a valuable group in the community (are they satisfied that you are doing a good job)?

If these can be answered in the affirmative and corroborated by other community sectors then the CHC has reached Level 3 in capacity by developing a network that is effective and they are respected in the community. Similarly, the ability to transfer knowledge, solve problems and develop a health infrastructure is measured by reference to the appropriate boxes.

For knowledge transfer two particular activities were perceived to be important by the CHCs. These were: 'Explain the SHSAC service model and the Katherine East Coordinated Care Trial timeline' and

TABLE 3: STATEMENTS OF ABILITY

Network partnerships	Knowledge transfer	Problem-solving	Infrastructure
Levels of capacity			
Level 1 CHC has ability to define groups (clans and power factions) within the community and initiate communication with them	**Level 1** CHC has the ability to engage community groups and discuss their health issues and explain the SHSAC service model and Katherine East Coordinated Care Trial timeline	**Level 1** CHC has the ability (with education team support) to identify and discuss community health issues as articulated by the community	**Level 1** CHC has the ability to call, run and document regular meetings with support from the education team
Level 2 CHC is recognised by the community as a legitimate conduit for health issues discussion	**Level 2** CHC has the ability to relay this knowledge accurately to SHSAC via the Board and can explain the process outlined in *The Money Story** to community members	**Level 2** CHC has the ability to instigate mechanisms for problem-solving, elicit support from SHSAC and coordinate problem-solving with the community, Board and SHSAC	**Level 2** CHC has acceptance by the community as the legitimate conduit for health issues, and works effectively with the education team to call and run meetings CHCs have an understanding of financial issues *(The Money Story)*
Level 3 CHC has ability to maintain the network between community groups	**Level 3** CHC has the ability to both relay issues to the Board and provide feedback to community groups on a regular basis	**Level 3** CHC has the ability to sustain a framework for problem-solving within the community	**Level 3** CHC has the ability to operate in the community without support from the education team, and is able to act as an effective community voice on health issues

* *The Money Story* is a training package designed to support Aboriginal people to become good financial managers, and has been developed by Pangaea Pty Ltd, Alice Springs

'Explain the process outlined in *The Money Story*' (a financial training package designed to support Aboriginal people). Both these activities were the focus of training carried out by the Community Development Unit and were the subject of two large training posters. The first activity involved the use of a poster to explain the main points of the Katherine East Coordinated Care Trial to the community as well as the setting up of SHSAC. This was essentially a pictorial representation of the rollout of the trial from signing the trial agreement with the Commonwealth Government and the Northern Territory Government, through incorporating SHSAC and community sign-up, takeover of clinics, delivering primary health care programs, and, finally, conclusion of the trial. *The Money Story*—the focus of the second activity—was developed by Pangaea Pty Ltd, Alice Springs—an organisation that focuses on capacity building, mainly with Aboriginal people. *The Money Story* is presented to participants in the form of a poster that translates the complexities of a financial balance sheet into an intelligible pictorial form. Pangaea Pty Ltd was contracted by SHSAC to build capacity in the Board, and also to support the Community Development Unit in its efforts to develop capacity with the CHCs. The two activities were seen therefore, as good indicators of the knowledge translation process as a whole—from the initial support given by Pangaea to the Community Development Unit in helping them develop their capacity building with the CHCs, to the work of the Community Development Unit with the CHCs and ultimately to the CHC's interaction with the community.

Discussion

The CHCs evaluated were drawn from the three target communities chosen for the trial evaluation. Group or individual interviews were conducted with members of each of the three CHCs as well as members of their respective communities using the instrument previously described. For the first assessment, individual interviews with community members, including those in sectors of the community indicated by the CHCs as key to network formation, were completed.

Extra interviews with individuals in the community were undertaken to verify that sectors of

TABLE 4: LEVELS REACHED AT TIME 1 AND TIME 2

	Network partnerships		Knowledge transfer		Problem-solving		Infrastructure	
	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2
Community 1	Level 1	Level 2	Level 1	Level 2	Level 2	Level 2	Level 1	Level 2
Community 2	Level 2	Level 3	Level 2	Level 2	Level 2	Level 2	Level 1	Level 2
Community 3	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1

the community indicated by the CHCs were indeed key stakeholders. At the second assessment, group interviews were used with relevant sectors of the community. The latter included health workers at the health centre, women at the women's shelter and men's groups consisting of influential men in the community and their associates. Group interviews were planned for the CHCs. However, because of pressing community business this was not always possible and in this case individual interviews with CHC members were resorted to. Participants were encouraged to elaborate on answers given in order to allow flexibility in responses.

By the end of the trial the CHCs were well established in two out of the three communities evaluated, with networks infrastructure and problem-solving well developed.

Knowledge transfer was the most difficult area to establish, particularly with respect to disseminating information through the wider community. This was to be expected as two of the indicators chosen in this area were connected with the rollout of the trial and *The Money Story* activity. As discussed in the previous section, both these activities relied on the training support mechanisms operating smoothly. In reality, this was often not the case. Training had often to be postponed because of the result of climatic conditions (such as flooded roads preventing access to a community) and pressing community issues (for example a death that effectively closed the community for a period) precluding any training activity.

Community 3 experienced the most difficulties and this was due in part to the fact that it was the last community to become part of the trial and had less time to develop. The problem of a large community and the lack of support of key institutions in the community also made it difficult for the CHC to establish itself as a recognised conduit for discussing and solving health-related issues. Community 2 was really the most fortunate being the smallest community and having engaged key community figures to work on the committee. Table 4 above summarises the assessment of each community at Time 1 and Time 2.

Conclusion

The Community Capacity Index used in the way described proved to be effective both as an evaluation tool and as means of engaging CHCs in their evaluation. Working first with the Community Development Unit, it was possible to develop the best means of engaging with the CHCs in order to elicit their trust and involvement.

Defining community capacity in terms of the four domains described made it relatively straightforward to communicate the concept of community capacity to the CHCs. Creating descriptive statements representing each domain of capacity and level of confidence then made it relatively straightforward to develop indicators with the CHCs.

Finally, a major objective mentioned at the start of this article was to ensure the CHCs got some value out of the evaluation process. The method described allowed sufficient involvement to facilitate an understanding of the process, while at the same time not being too onerous where the process might detract from active involvement. The ongoing interest and involvement of the CHCs throughout the period of the trial inferred the balance was probably about right.

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References

Bush, R, Dower, J & Mutch, A 2002, *Community Capacity Index Manual: Version 2*, Centre for Primary Health Care, The University of Queensland, Brisbane.

Crisp, BR, Swerissen, H & Duckett, SJ 2000, 'Four approaches to capacity building in health: consequences for measurement and accountability', *Health Promotion International,* vol. 15, no. 2, pp. 99–107.

Wakerman, J, Humphreys, J, Wells, R, Kuipers, P, Entwistle, P & Jones, J. 2007, *A systematic review of primary health care delivery models in rural and remote Australia 1993–2006*, Australian Primary Health Care Research Institute, Canberra.

WHO 1978, 'Declaration of Alma-At', International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September.

WHO 1986, 'Ottawa Charter for Health Promotion', First International Conference on Health Promotion, Ottawa, 17–21 November.