Revealing the hidden ‘troubles’ in Northern Ireland: the role of participatory rapid appraisal

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Abstract

Our objectives were to explore the use of rapid participatory appraisal (RPA) in defining the health and social needs of women, and to formulate joint action plans between the residents and service providers. RPA included review of existing data, focus groups and questionnaire. The study was set in the Ardoyne area of North Belfast. A response rate of 85% was obtained. Priorities identified reflected holistic definition of health and included issues relating to physical environment, social supports, as well as traditional epidemiological data. The use of RPA in this study has demonstrated a greater insight into unmet health and social needs in the area. It has exposed the level and extent of poverty, such as poor nursery provision for the under 5s, lack of safe play areas, fuel poverty for the elderly person, high dependence on prescription drugs such as valium and antidepressants, as well as lack of access to specific services due to political boundaries.

Introduction

Participants at the Primary Health Care (PHC) 20th anniversary conference unanimously agreed that the PHC philosophy should remain valid into the 21st century (WHO, 2000). Participants acknowledged that significant progress had been made over the last 20 years, most notably in the coverage of populations with essential health care; however, progress in the fundamental approaches to service delivery has remained slow [(WHO, 2000), p. 5]:

...there has been less success in the development of sustainable health systems, inter-sectoral approaches and community participation.

This observation is not new (Rifkin and Walt, 1986), and the challenge of collaborative working across different disciplines, sectors and with communities remains the obstacle to actualizing the vision of PHC. As the promotion of equality is the driving force for the public health agenda, the new NHS philosophy is encouraging patient choice and the tailoring of the process of care to benefit the patient or consumer. Underpinning this shift towards partnership is the view that better outcomes will be achieved for people and communities using services. The word ‘partnership’ is now used to denote a shift to greater equality in relationships. However, true participation of the public in decision making and evaluation of health care has been more difficult to promote in practice, particularly in poorer, more deprived areas (Statham, 2000). Moreover, despite a long history of community development in the UK and much experience in the use of participatory approaches, little of this has been formally published.

Equity

Traditionally participatory methods have tried to reduce barriers to access for people who are disadvantaged by targeting services in a variety of ways. Sen demonstrates, however, that the provi-
sion of equal services to unequal populations can create or exacerbate inequity, thus making the concept of needs-sensitive services central to ensuring equity (Sen, 1992). In practice, available resources are not always allocated equitably to assist different social groups who may be facing limited access and barriers to healthcare perhaps of a geographical, cultural, religious or financial nature.

Equity and social inclusion are central to Northern Ireland’s health and social policy (Department of Health and Social Services, 1997; New TSN, 1998). Targeting Social Need (TSN) is a policy aimed at securing greater equality of opportunity and equity by targeting resources on the most disadvantaged areas and people. This current policy and the new political environment in Northern Ireland is conducive to the implementation of community-based approaches and the use of participatory methods as a way to reduce health inequalities and alleviate poverty. Therefore, to contribute to the TSN agenda, healthcare practitioners must have a clear understanding of the health needs of the community with which they are working.

Northern Ireland is recognized as having some of the greatest levels of health and social inequalities in the UK (Campbell, 1993; Haycock and Henscher, 1995; Moore et al., 1996). These inequalities are directly related to socioeconomic and cultural factors that are not adequately addressed by the more medically dominated model of health. Three decades of political conflict has intensified the effects of poverty and has resulted in the province being recognized as the most disadvantaged region in the UK (Harris et al., 1990; Oppenheim and Harker, 1996; Office of National Statistics, 2000). Northern Ireland is not alone in having widening social inequalities in health, poverty and social exclusion. Within the UK, the publication of the Independent Inquiry into Inequalities in Health (Acheson, 1998) has reviewed the evidence on inequalities in health and identified priority areas for future policy development. This much-awaited report illustrates a significant shift in government policy in its acknowledgement of health inequalities as a major problem. The Inquiry highlights three areas that it regards as important for future developments, i.e.

- All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities and should favour the less well off.
- High priority should be given to improving the health and reducing inequality for women of child-bearing age, pregnant women and young children.
- Steps should be taken to reduce income inequalities and improving living standards of poor households.

**Participation**

Over recent years there has been a growing interest in the use of participatory approaches and, in particular, in their value in improving the health of communities. This can be traced back to the Alma-Ata Declaration of 1979 that made community participation a central component of primary health care policy. It highlighted that [Alma-Ata Declaration IV (WHO, 1978)]:

> The people have the right and the duty to participate individually and collectively in the planning and implementation of their health care.

The arguments put forward for this were that:

- Poor use of health services could be attributed to lack of community involvement.
- All available resources should be mobilized.
- Community participation can enhance the effectiveness of health promotion.
- Communities should be involved in the decisions that concern them.

An understanding of the beliefs, culture and aspirations of a community is central to effective health promotion, and this can be best achieved through the active participation of the population. As there are many definitions of community and participation, so there are a number of ways in which community participation has been theoretic-
ally constructed. Participatory needs assessment is not a new concept (WHO, 1986, 1996). Examples of participatory needs assessment are more prevalent in developing countries (Scrimshaw and Hutardo, 1988; Thies and Grady, 1991; Ong, 1991; Shamian and Kupe, 1993; Varkevisser and Alihonou, 1993). Traditionally, health services plan distribution on the basis of service use, but this approach has been shown to exacerbate problems associated with social exclusion (Freire, 1996). This approach may also contribute to the vicious cycle by which services become progressively less responsive to the very people they are meant to serve [(Klouda, 1993), p. 17].

The theoretical construct of empowerment underlies many participatory approaches. Empowerment is a complex notion that was rooted in the civil rights and women’s movement of the 1960s, and the self-help perspectives of the 1970s (Braye, 1995; Myers and Macdonald, 1996). It stresses the inability of people to take control of their lives, and the need to provide them with the skills, knowledge, and confidence and power to take collective action. Participatory research is primarily differentiated from conventional research in its alignment of power within the research process (Cornwall and Jewkes, 1995). Arguably, ‘participatory research’ consists less of models of research that merely involve the community in data collection than of those which address issues of the setting of agendas, partnership of results, power and control.

In the current climate of needs-sensitive service, participatory rapid appraisal (PRA) is gaining popularity as a research method (Scrimshaw and Hutardo, 1988; Shamian and Ong, 1991; Thies and Grady, 1991; Kupe, 1993; Varkevisser and Alihonou, 1993; Murray et al., 1994; Annett and Rifkin, 1995; Chambers, 1997). PRA has been used by community workers and primary healthcare teams to gain public involvement in the assessment of needs from Glasgow to inner city London and from Belfast to Sweden. To reflect adequately the multidimensional nature of health, needs assessment and subsequent service planning and delivery requires a multidisciplinary, intersectoral and community approach (Department of Health and Social Services, 1997; New TSN, 1998).

Community participation in action

This case study has been chosen to illustrate the use of PRA as a method used to assess the health and social needs of women in the deprived Ardoyne area of Belfast. Ardoyne, in North Belfast, with a population of around 7000 has some of the most concentrated deprivation in the UK. Based on the 1991 Census statistics, Ardoyne has been ranked the fifth most disadvantaged ward in Northern Ireland (Townsend et al., 1988) and unemployment is recognized as one of the most serious problems facing the area today (Mallet, 1997; Wilde, 1995), resulting in a situation of high dependency and low average household income levels.

Levels of deprivation in North Belfast have been compounded by the heavy burden suffered by the area from the Northern Ireland troubles and Ardoyne has, according to The Hidden Troubles (Mallet, 1997), experienced some of the highest numbers of deaths in the province. This combination of violence and deprivation has had a crucial impact on health and the quality of life in the area. The association between poverty and ill health is well established, so it comes as no surprise that the health profile of Ardoyne residents is poor. The standardized mortality ratio (SMR) for all causes of death under 65 is 164; there are particularly high rates of respiratory disease (SMR 156), heart disease (SMR 154), cancers (SMR 153) and injury (SMR 213). The area has a younger population structure than other wards in Northern Ireland, and has the highest proportion of births to teenage and single mothers, as well as one of the highest rates of infant mortality. It has some of the lowest rates of immunization and a high rate of community members suffering from long-term illness (Haycock and Henscher, 1995).

PRA

PRA is one example of a framework that has been developed to turn the theoretical constructs
of community participation and empowerment into theories for practice. PRA is primarily a tool for participatory diagnosis and planning, culminating in the formulation of action plans jointly with those agencies that have the resources to meet the needs identified. The resulting improvements in a community’s access to health information and services can empower them to influence and develop services, contributing to the overall sustainable development of the population.

PRA provides fast relevant information for decision makers on priority issues, is very much a team exercise and is always carried out with the community. Data collection is based on the concept of ‘triangulation’. This is the use of data from a variety of sources and methods to strengthen needs assessment, in that if all data point in the same direction it may be reasonably assumed that the insights gained are valid and have scientific rigour.

Once areas of concern have been identified, it is essential that the information gained is fed back into the community in order for them to identify priorities for action, thus strengthening the principles of equity and participation. The information gathered can form a baseline for assessing the impact of interventions and services on the improvement of health and social need within the community. The PRA process contributes to sustainable development by building upon a community’s strengths in the identification of resources available to meet identified needs.

**Aims**

The case study aims were to demonstrate the use of participatory rapid appraisal in:

- Gaining insights into women’s health and social needs which are based on their own and other agencies perspectives over a short period of time.
- Assessing any gaps in existing services.
- Assessing barriers that prevent certain groups from accessing services.
- The translation of these findings into action.
- Establishing partnerships between service providers, voluntary organizations and local communities.

### Table I. Summary of stages in PRA

<table>
<thead>
<tr>
<th>Define PRA</th>
<th>Define what information is needed</th>
<th>Decide how to obtain information</th>
<th>involve the community in RPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>key informant interviews</td>
<td>observation</td>
<td>secondary documents</td>
<td>Collect information</td>
</tr>
<tr>
<td>Analyze information</td>
<td>Review findings with community</td>
<td>Define priorities</td>
<td>Programme of change</td>
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### Methods

Annett and Rifkin advocate the use of an information pyramid in collecting and analyzing data in PRA exercises (Annett and Rifkin, 1995). The pyramid covers nine aspects used to assess community health needs ranging from defining the community structure and organization, as well as its capacity to act through to the holistic factors that can determine health and, finally, the local policies such as TSN as well as national and international policies that are committed to community participation in health. Table I defines the various aspects as stages.

A 20 person PRA team (Box 1) comprised of representatives from the local community and a range of disciplines and organizations, met together at an initial workshop to assess the women’s health needs within the Ardoyne community (Box 2). The logistical difficulties inherent in a large team prompted the formation of a smaller sub-team of six team members (indicated by an asterisk: health center staff, two university researchers and a member of staff from the Royal College of Nursing) who contributed 4 h per week over the 3-month period of the study.

It was agreed to use three sources of data collection, i.e. existing written records about the neighbourhood (Box 3), interviews with a range of key informants drawn from the local community
Box 1. PRA team membership (*sub-team membership)
Two academic staff members—The School of Nursing and Midwifery, Queen’s University of Belfast
Board Secretary—RCN
Head of Education—RCN*
Staff Member—Flax Centre, Ardoyne
Making Belfast Work Representative
Director of Nursing—North and West Belfast Trust
Voluntary Organization—Lifestart
Health Centre Manager*
GP from Health Centre*
Coordinator Health Centre
District Nurse
Nurse Practitioner*
Chairman British Medical Association
Community Assistant in Health Centre
Community Worker
Community Housing Facilitator
Ardoyne Women’s Forum
Community Women’s Group Members
Carer and Women’s Forum Member

Box 2. Objectives of the workshop—what is PRA
Define the area of focus
Define work programme and timetable
Agree understanding of the main context and limitations of RA
Set up focus groups to generate questions
Conduct a survey with the community
Analyse existing data and priority setting

Box 3. Sources of written information
Census statistics
Planning records
Surveys already undertaken in the area
Government agencies
Professional organizations
Universities
Health providers
Reports of studies undertaken within universities
Historical records
Regional health statistics
Records relating to housing/environment
Internet search
Hospital records
Studies and surveys by other agencies

Box 4. Key informants
Government officials
Social and health service personnel
Teachers
Pharmacists
Patients
GPs
Legal profession
Media networks
Community leaders: women’s groups, support groups, community organizations
Voluntary agencies

and service providers (Box 4), and focus group interviews and a community health survey carried out by community members themselves.

The PRA team carried out interviews with key informants including local health and social service professionals, voluntary organizations, and community groups. While this data can enhance the understanding of identified problems, the influence of personal biases and prejudices on the part of informants was always borne in mind.

Twenty members of the community participated in two focus group discussions. Each group had 10 members of the community, and was led by a skilled facilitator and a researcher to record the findings. A semi-structured interview schedule was prepared, which took the form of a broad framework of issues adapted from the pyramid. The goal was to elicit the community views and opinions of the locality through a guided questioning route, and for the sub-team to emerge from the focus group with a deeper understanding of the ‘community’s’ priority health and social need issues. The group also discussed how to improve the uptake of existing services and new ways to meet gaps in services.

A women’s health needs survey was constructed from this information. The focus groups perceived causes of ill health to include aspects of women’s health such as lifestyle, mental health, sexual and reproductive health, nutrition and leisure, disability, caring, violence, children, education and communication, and access to services. Ten community representatives (funded by Glaxo Wellcome)
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agreed to undertake the community survey and subsequently received training in interview techniques. The survey material was piloted on 10 households by these representatives to assess face validity.

A target group of 100 households (random selection of 10 houses in 10 streets) was defined as a sub-group of the community and each of the 10 community representatives carried out the survey. Consent was obtained from the respondents and they were given written material outlining the purpose of the survey.

Data analysis

The women’s health needs survey achieved a response rate of 85% (n = 85) and results were analyzed using the Statistical Package for the Social Sciences (SPSSPC, 1995). The mean age of the community respondents was 33 years (range 22–54 years). Almost a quarter (22%) of the women were employed full-time, 35% were in part-time work with low incomes and 43% were classified as unemployed.

Content analysis using a framework based on triangulation techniques was used for analysis of qualitative data collected through focus groups and from secondary sources. This resulted in the identification of six main categories and associated priorities. This information (categories and associated priorities) was subsequently presented on individual index cards. To facilitate comparison between professional and local priorities, a group of GPs from two local health centres (n = 6) and the PRA team (n = 6) were first invited to give each item a priority ranking. At a feedback meeting, the community representatives (n = 25) were invited to place these priority lists in rank order. This exercise started a two-way discussion about the opportunities for change during which the PRA team learned more about the main concerns of the community, the limitations of statutory services and the need to prioritize problems. Discussing all of the results with the community allowed for joint interpretation of the data, and increased the cultural and internal validity of the results.

Subsequently all the data on each category was reduced to a number of statements which described the key needs for the community. This priority-setting exercise determined whether the priorities chosen by the community members were of equal weighting to those chosen by the GPs in the area and of the PRA team. The comparisons could then be drawn using a statistical comparison or weighted approach. The three Ardoyne sets of rankings were analyzed separately to assess the extent of agreements amongst the ‘judges’ (the GP team, the PRA team and the community) by utilizing Kendall’s coefficient of concordance. This analysis of the rank-order data employs a non-parametric statistical technique to examine the level of agreement between each of a set of judges. These individuals have to rank order their priorities in each of the selected categories and their scores are compared with each other within a category, and the lowest score denotes the highest priority. The mean rankings are presented in Table II.

The results of the PRA are discussed under the six priority categories identified.

Physical environment

The community, GPs and PRA team had all ranked political boundaries (the ‘troubles’) and problems with access to services at the top of their priority list (see Table II). The highest priority for the community was the problem of transport due in many cases to poor car availability and limited bus services. These findings are supported by the survey results which revealed that 75% of the community felt there is limited access to efficient and cheap transport, there are problems with political boundaries (86%), and lack of leisure facilities in Ardoyne (45%). All of the respondents were concerned about the lack of crèche and preschool facilities, and the safety of their children in the streets due to lack of play areas for toddlers and young children. The legacy of a generation of ‘the troubles’ combined with all of these factors contributed to a collective sense of isolation amongst women in the area, in particular, older women and those with young children.
Revealing the hidden ‘troubles’ in Northern Ireland

<table>
<thead>
<tr>
<th>Table II. Categories of women’s health needs and priority issues (mean ranks)</th>
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<tbody>
<tr>
<td>GP team view</td>
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<td>(n = 6)</td>
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<tr>
<td><strong>Physical environment</strong></td>
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<tr>
<td>political boundaries (‘troubles’)</td>
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<tr>
<td>transport</td>
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<tr>
<td>lack of facilities</td>
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<tr>
<td><strong>Disease</strong></td>
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<tr>
<td>breast cancer</td>
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<tr>
<td>cervical cancer</td>
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<tr>
<td>heart disease</td>
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<tr>
<td><strong>Mental health issues</strong></td>
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<tr>
<td>depression</td>
</tr>
<tr>
<td>stress</td>
</tr>
<tr>
<td>anxiety and fear</td>
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<tr>
<td><strong>Lifestyle</strong></td>
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<tr>
<td>smoking</td>
</tr>
<tr>
<td>alcohol problems</td>
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<tr>
<td><strong>Access to services</strong></td>
</tr>
<tr>
<td>baby clinic</td>
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<tr>
<td>well-woman clinic</td>
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<tr>
<td>asthma clinic</td>
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<tr>
<td><strong>Socioeconomic</strong></td>
</tr>
<tr>
<td>poverty</td>
</tr>
<tr>
<td>unemployment</td>
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<tr>
<td>low pay</td>
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</table>

The streets are not safe for children. I know there are certain houses that have paedophiles who regularly taunt young girls and boys and try and buy favours.

**Disease**
Breast cancer was ranked the top disease priority by community representatives; GPs also felt that breast cancer and cervical cancer were priorities, however, their highest priority was heart disease (see Table II). Reasons for this disparity of views may be found in the survey results which show that a strikingly high percentage of women (31%) had personal experience of breast or cervical cancer (age range 31–53 years). Uptake of preventative services is traditionally lower in areas of social deprivation; however, 70% of the women had availed themselves of cervical screening at an Action Cancer mobile screening unit which came to the Health Centre in the previous year.

The highest mental health priority for the GP group was the level of depression, while anxiety and fear were ranked highest by both the community and the PRA team (see Table II). Mental health difficulties were self-reported by over half of the survey group, ranging from severe stress (62%), depression (53%) to anxiety/worry (24%). Mental health problems were more prevalent in women who were looking after a family and were living in an unemployed household (68%) with very low incomes. Primary health care professionals showed considerable awareness of the ‘fragile’ mental state of many of these women and how this was related in the

I can’t believe the number of families I know in this area who have some relation living with cancer. It is scary the number of young women who have it—I thought you only got it if you were older.
survey to high rates of repeat prescriptions. This included 21% of the women in the survey asking for repeat prescriptions for sleeping tablets, 25% for tranquillizers such as valium and 42% for anti-depressants. Also, 12% of the survey respondents stated using recreational drugs such as cannabis for relief of stress and anxiety.

I am unemployed with no family support and I feel alone all the time. Being on your own with a young child can be very depressing as most of the time you have no one to talk to.

Lifestyle
Smoking was ranked as the highest priority within lifestyle issues for all the groups, but particularly for the GP team (see Table II). The survey revealed that 72% of the women smoked despite having a comprehensive knowledge of the potential hazardous effects of their health. Smoking was seen as a stress reduction strategy for many women (58%)—a finding supported by other research (Graham, 1993; Wilkinson, 1996). Alcohol problems were high priority for the GP team and less so for the survey respondents. The survey illustrated that consumption was reported to be well within safe limits (58%); while smoking formed an integral part of the daily routine for almost three-quarters of the women, drinking alcohol was an activity for one or two evenings a week. Even under stress 73% of the women claimed that they would not turn to drink as a coping strategy. However, a small number (8%) stated that they would be more likely to drink heavily if under stress and they needed to calm their nerves.

Every Monday I try to stop smoking. It never works as I think I smoke to take my mind off other worrying things in my life.

Access to services
The GPs and the PRA team both ranked the establishment of an asthma clinic as the top priority in terms of service provision; however, for the survey representatives a well-woman clinic was highest on their priority list, followed closely by a baby clinic (see Table II). These priorities are echoed in the findings of the survey which revealed that 24% of the women and their children had attended casualty during the last 12 months, and 80% had seen a GP. Generally comments about primary care services were favourable; however, 65% of the women felt that there were particular problems of access, and barriers to services and facilities these difficulties were related to lack of access to a car, lack of childcare facilities and political boundaries. The main suggestions for improvements of services were the introduction of well-woman and child health clinics, stress management and general health promotion groups including smoking cessation and healthy eating.

The ‘troubles’ still have a large effect on this community as there are political boundaries everywhere. I am still very uneasy about walking through certain areas to get to a baby clinic.

Socioeconomic conditions
Poverty and unemployment were very closely linked as they were given equal ranking as top socioeconomic priority by the community; significantly, the PRA team and the GP group also registered unemployment their highest priority (see Table II). The survey results support these findings, with 80% of the women expressing fears and insecurity associated with lack of paid employment and money generally. The lack of jobs that fitted with school hours was compounded by a lack of appropriate and affordable childcare. Life was perceived as a struggle to make ends meet as women expressed concerns about providing for their children, both in terms of necessities such as food, clothes and shoes, but also in terms of ‘treats’ like days out and holidays. Older women expressed most concern about heating bills, costs which were incurred maintaining a high level of heating because of a sick or disabled person in the household. The combination of low income, debts and the inability to afford certain major items was clearly having a negative effect on the women’s quality of life.
To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debt, to feel devalued, useless, helpless, hopeless, anxious, isolated: these feelings can dominate people’s whole experience of life, colouring their experience of everything else. It is the chronic stress arising from these feelings which does the damage. It is the social feelings which matter, not exposure to a supposedly toxic material environment. [(Wilkinson, 1996), p. 215]

It is very clear from the PRA that problems with physical health are connected with a wide range of factors relating to unemployment, stress, environmental conditions, political boundaries, financial circumstances, behaviours and lack of health promotion in the area. Concern among GPs in the area is about coronary heart disease and other smoking-related health problems such as cancer, respiratory and circulatory diseases, and is consistent with the available statistics. However, for the women in the community there is perhaps a rather different perception of the relative importance of heart disease as opposed to respiratory and breast and cervical cancer.

Particular complex problems were highlighted by the younger woman with children such as financial difficulties, problems of access to work (due to lack of affordable childcare facilities), children with asthma, poor diet and smoking, and isolation and lack of parenting skills leading to worry and depression. In several cases these were exacerbated by several young women having serious health problems such as breast and cervical cancer. One woman stated that: ‘cancer is like the common cold in Ardoyne’.

**Discussion**

Equity and partnership have been identified as central to effective health promotion (WHO and UNICEF, 1978; WHO, 1986, 1999); however, integration of these concepts into mainstream practice has proved to be elusive (WHO, 2000). The skills required are different from those required in traditional hierarchical practice.

This case study demonstrates that the creation of a coherent needs-assessment methodology built on both objective and subjective definitions of need which takes into account community diversity as well as the central issue of inequality is a formidable challenge. However, the advantages of seizing the challenge are worth the effort required. The case study shows that PRA proved to be a useful tool for participatory research as it broke down the traditional barriers between researchers and participants, and provided a vehicle for power sharing in decision making between civil society and health care providers.

By bringing together professional and users’ views on health and social need in the area, PRA transcended the traditional barriers of prejudice and different values (Seedhouse, 1997). There was considerable difference in terms of priority setting between the individual, professional and statutory groups and the community. However, the differences which existed between professional groups highlight the importance of inter-agency and multi-disciplinary responses to health and social problems. Community participation is central to the concept of sustainability and is a fundamental part of action research (Rifkin and Walt, 1986). The women in the community perceived the need for change, and were willing to play an active part in the research and the change process. In this sense community participation was central to the study as the collective community was actively engaged in identifying and planning for their health care, and ultimately was involved in influencing decisions that concerned them. The findings suggest that many single-agency or single-professional responses are likely to result in measures that are out of tune with residents’ own perceptions of needs and priorities. The ultimate goal, however, is not to illustrate the sameness, but a respect for diversity and the generation of new skills to cope with the differences in perspectives and values, and hence in priorities about options and acceptable risks.

Needs assessment cannot be divorced from issues of effectiveness and cost-effectiveness, priority setting, and the uneasy balance between
individual or population health gain. PRA offers an alternative to more formal and resource-intensive methods of gaining public and professional perceptions of need. It does so by placing participants firmly at the centre of a research process aimed at determining health and social needs, identifying gaps and barriers to accessing current health care services, and formulating strategies for addressing these needs over a comparatively short period of time.

The team approach resulted in a holistic assessment of health and social need providing a powerful baseline for assessing the impact of services on the improvement of the life and health of the population. In Ardoyno, where health and social services management is largely localized, PRA provided a powerful vehicle for active participation of civil society in planning and evaluating services. Used in conjunction with more conventional quantitative methods PRA is able to contribute to a more sustainable and needs sensitive service.

The results show that, despite intensive dialogue, the understanding that professionals have regarding the community’s problems are mediated by resource restrictions and professional biases. This is not to dismiss professional judgment but rather to illustrate the complexities involved in partnership, sharing information and understanding needs. Smoking was the highest priority issue for all the groups in the study. However, it is interesting to note that women did not identify smoking cessation as an important health issue. In pursuing this issue, cognizance of the reasons why women smoke is of vital importance. Graham (Graham, 1988) highlights the strong association between poverty, stress and smoking, and Wilkinson (Wilkinson, 1996) argues that higher levels of behavioural risk-taking among poorer people reflect high levels of chronic stress rather than ignorance of the health risks associated with smoking. The study also revealed a high prevalence of dependence on prescription drugs such as valium and antidepressants which further reinforces the theory that addictive behaviours amongst women in the area is a coping mechanism for stress.

A health care system based on the concept of equity (Sen, 1992) will place health needs assessment within a holistic context. For many low-income families, without substantial changes in social policy, there is little hope that their circumstances will change for the better in the near future. PRA is one approach that seeks to mitigate against the effects of poverty and social exclusion on health. PRA promotes the active participation of civil society and mobilizes the synergistic potential of intersectoral collaboration in the identification of health need priorities and developing responses. This collaborative approach results in the provision of accessible and appropriate services, which aim to enable individuals, families and communities to achieve their full potential. More importantly, by providing a vehicle for solidarity between civil society and professional health workers, PRA enhances the capacity of all parties to influence policy development.

Conclusion

The case study emphasizes the problems of urban deprivation, placing the problems of political boundaries and unemployment as high priorities. The PRA team feel that as well as exposing the level and extent of poverty in the area, the methodology has given them insights into unmet health and social needs. A programme of change has been established with the following outcomes.

Immediate outcomes

- A health forum has been established to include members of statutory, voluntary and community groups. This is allowing more permanent dialogue between the community and professionals, and action plans have been instigated and evaluated, as many of the important health and social needs could not be met by health services alone.
- The PRA team have been able to transfer skills and information to local women so that they can work to secure resources for the community. Outside funding is being sought from the National lottery for the creation of Lay Health Worker Schemes in the area.
Intermediate outcomes

- One GP has responded to the feedback from the community and identified a need for a nurse practitioner in the health centre. The post is now filled and the nurse practitioner’s role is to facilitate the health of the women in the community by providing a well-woman clinic, stress management classes, alternative therapies and smoking cessation groups.
- The Trust is also introducing an asthma and baby clinic into the health centre.

Longer-term outcomes

- Baseline information such as this can be linked to longer-term outcomes such as rates of smoking cessation, improvements in housing conditions, increased child immunization, increased screening rates for women, increased access to services, etc. Information such as this can allow a comparison of these issues at a later time.

Finally, the study highlights that the research design must be continually negotiated with participants and that there is a need for an ethical democratic code of practice which sees the participants and that there is a need for an ethical design must be continually negotiated with participants and that there is a need for an ethical design must be continually negotiated with participants.

References

and selective primary health care. Social. Science and Medicine, 23, 559–566.

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