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## **Community Assessment Workshops: A group method for gathering client experiences of health services**

### **Abstract**

Community assessment workshops were developed to gather client experiences of primary health care services in Australia. Primary health care services are particularly concerned with working with disadvantaged populations, for whom traditional client survey methods such as written surveys may not be inclusive and accessible. Service staff at six Australian primary health care services, including two Aboriginal-specific services, invited participants to attend workshops in 2011-2012. Participants were offered transport, childcare, and an interpreter, and provided with reimbursement for their time. Ten workshops were run with a total of 65 participants who accessed a variety of services and programs. A mix of age and gender was achieved. The workshops yielded detailed qualitative data and quantitative rankings for nine service qualities: holistic, effective, efficient, culturally respectful, used by those most in need, responsive to the local community, increasing individual control, supports and empowers the community, and mix of treatment, prevention, and promotion. Discussion was audio recorded and transcribed for qualitative analysis. The workshop approach succeeded in being 1) inclusive, reaching users from disadvantaged sections of the community; 2) comprehensive, providing ratings and discussion that took account of the whole service; 3) richly descriptive, with researchers able to generate detailed feedback; and 4) more empowering than traditional client survey methods, by allowing more control by participants and greater benefits than surveys of individuals. The community assessment workshops are a method that could be widely applied to health service evaluation research where the goal is to reach disadvantaged communities and provide ratings and detailed analysis of the experience of users. The participants and the research benefited from the group approach, and the workshops provided valuable, actionable information to the health

services. Recruitment of users, particularly those from culturally diverse backgrounds, remains one of the key challenges facing evaluators.

### **Key words**

focus group, primary health care, clients, evaluation

### **What is known about this topic**

- Traditional approaches to client surveys have shortcomings in inclusiveness, usually generate high approval, and do not yield rich, descriptive data
- Primary health care includes an explicit focus on disadvantaged communities which may need to be engaged in different ways to be included in evaluation efforts

### **What this paper adds**

- This community assessment workshop method provides a tool for the inclusion of clients from disadvantaged communities in evaluation efforts
- The workshops provide detailed information on client experiences that can be used for quality improvement
- The workshops also benefit clients, providing more benefits and opportunities for empowerment than traditional survey methods

## Introduction

Many evaluators seek the input of users of the health service in evaluation. Traditionally, this has most often taken the form of quantitative pen and paper surveys (Wensing *et al.* 1998, Wensing & Elwyn 2002). However, these often generate high satisfaction ratings with little power to detect and explain less satisfactory experiences (Wensing & Elwyn 2002). There is growing recognition that evaluation can be conducted in a way that is participatory and empowering. The ground gained by methods such as participatory evaluation (Brunner & Guzman 1989), empowerment evaluation (Fetterman 1994), and community based participatory research (Minkler & Wallerstein 2011) highlight the importance of such collaborative and respectful approaches. This paper reports on a community assessment workshop process developed for the evaluation of Primary Health Care (PHC) services in Australia as part of a five year, multi-site study on the evaluation of comprehensive PHC services.

Comprehensive PHC is an approach to health care provision and health promotion that emphasises multi-disciplinary teamwork, equity, empowerment and community participation, disease prevention and health promotion in addition to direct care and treatment, and a social view of health that takes into account the social determinants of the health of the local community (World Health Organization 1978). Comprehensive PHC thus has an explicit focus on engaging with more disadvantaged communities. The PHC services participating in this research were either Aboriginal specific services (one Aboriginal community controlled health organisation, and one state managed Aboriginal health team) or had priority populations that included Aboriginal and Torres Strait Islanders, newly arrived migrants, and people on low incomes. It is vital for health service research to contribute to the health equity agenda through engaging with, and examining the causes of, health care disparities for such groups (Hasnain-Wynia & Beal 2012). Hence we sought to develop an

evaluation method that would complement the use of client surveys to support the inclusion of the experiences of these clients. The method was guided by four principles:

1. Inclusivity (Minimize transport, literacy, and other barriers to participation to allow anyone the opportunity to participate)
2. Comprehensiveness (Bring together a group to evaluate the whole service)
3. Rich descriptiveness (Generate detailed information to aid understanding and service improvement)
4. Empowering (Provide participants with more control and benefits than more traditional methods)

A group method was desired rather than one to one interviews to allow more reflection and debate on how to rate the service. Group methods can add more value than a series of one to one interviews when group dynamics can indicate reasons for different experiences, and allow participants to build on other participants' contributions (Krueger & Casey 2000, Lindlof & Taylor 2002).

Details of the project and the development of the method are presented below, followed by a discussion of how the method achieved these aims.

### **Participating primary health care services**

The workshops were conducted as part of a wider, five year project funded by the Australian National Health and Medical Research Council to evaluate the comprehensiveness of six PHC services in Australia. A major focus of the project has been the development of program logic models (Cooksy *et al.* 2001) in collaboration with the services.

The five South Australian and one Northern Territory PHC services participating in the study were selected based on pre-existing relationships that made an in depth, five year study feasible, as well as to maximize diversity. The services ranged from longstanding examples of PHC to newly emerging models, and included an Aboriginal Community Controlled Organisation, Central Australian Aboriginal Congress in Alice Springs, Northern Territory, a sexual health non-government organization, SHine SA (both of whom requested to be identified in publications) and four metropolitan services directly funded and managed by the South Australian state government.

### **Development of method**

The method developed was adapted from Laverack's community capacity workshops (Labonte & Laverack 2001). Laverack's workshop method was developed to enable community members (typically an already convened group of stakeholders) to self-rate their community's capacity in nine different domains. The method was chosen as it has been employed successfully in a range of countries and with different cultural groups (e.g. Labonte *et al.* 2002, Laverack 2003, Laverack 2005), including with Aboriginal and Torres Strait Islander health teams in Queensland (Lavarack *et al.* 2008). We adapted the method to focus on bringing a spectrum of clients together to rate the service qualities of a PHC service.

### **Service qualities development**

The service qualities were derived from the Southgate program logic model for comprehensive PHC in Australia (Lawless *et al.* 2011), an overarching logic model developed alongside the service-specific models. The logic models, and the service qualities they present, were developed jointly by the researchers, based on literature and experience, and by PHC staff, managers, regional health service executives, and departmental funders, through a total of 68 interviews, and 2-3 program logic model workshops at each of the six

services. This included strong Aboriginal and Torres Strait Islander participation: 17 of the interviews were with Aboriginal and Torres Strait Islander staff members, and for the program logic model workshops at the Aboriginal-specific services, all or a majority of participants were Aboriginal or Torres Strait Islander. The Southgate model of Comprehensive PHC and service-specific logic models were endorsed by representatives of each service at a research symposium in 2010.

The Southgate model articulates how comprehensive PHC principles, such as community participation and multi-disciplinary teamwork, may be facilitated or constrained by the service's operating environment and the wider context the service sits within. The model depicts how the principles shape what activities a service undertakes, and the way a service undertakes them (what we termed 'service qualities', such as holistic, and responsive to community needs). The service qualities derived from the model and used in the workshops are presented in Table 1. The plain language definitions were developed through a series of research team meetings where they were revised and refined to make the language as accessible as possible, while ensuring they still reflected an accurate description of the service quality. The final list of service qualities and definitions was circulated to services for comment before the workshops were conducted. No changes were requested.

[Insert Table 1 about here]

The model describes the anticipated outcomes for the local community of a service's work (activities and service qualities), such as decreased rates of preventable conditions, and a more supportive local environment for health. The site-specific models were variants of this overarching model using the same framework but with service-specific details.

## **Community Assessment Workshops**

The community assessment workshops engaged a group of users of each service in discussion and asked them to rate the extent to which the service achieved the service qualities. For each quality, a lay definition was presented (see Table 1) and discussed to

check understanding. Then five statements were handed out in random order to participants, ranging from no achievement of the service quality through to outstanding achievement of the service quality. An example set of statements for 'holistic', is provided in Table 2. The full set of statements for all nine service qualities is available as supporting material online. Participants and facilitators read out each of the statements in turn. The group was then asked to discuss their experiences and come to a consensus on which statement best reflected the health service for each quality. The researchers could then translate the chosen statement into a rating from 1 to 5, as indicated in Table 2, and also scribe on butchers paper at the front of the room the factors and experiences discussed when selecting this rating. Participants were then asked what they would change to improve the service's achievement of the service quality, and this was also scribed. This process was followed for each of the nine service qualities. The workshops were also audio-recorded and transcribed to capture greater detail and allow inclusion of quotes in the evaluations.

The method was approved by the Southern Adelaide Health Service / Flinders University Human Research Ethics Committee, the Aboriginal Health Research Ethics Committee, South Australia, and the SA Health Human Research Ethics Committee.

[Insert Table 2 about here]

The workshop method was piloted at a non-participating PHC service. Thirteen service users participated, and findings were fed back to the service manager and staff. Minor alterations were made to the process and wording of statements to aid clarity.

A total of 10 workshops were conducted at the six participating PHC services. Workshops were run at the PHC service or in one instance, a hired space nearby. Attendance at the workshops varied between 2 to 10 participants (see Table 3), giving a total of 8-16 clients

per service. The majority of participants were female (69%), reflecting the higher rate of women's use of PHC services (Smith *et al.* 2006). Participants were recruited through practitioners, who provided selected clients with the information sheet and details of the time, date, and venue of the workshop. Though we were conscious of introducing selection bias by allowing staff to select clients (Pelham & Blanton 2007), we were aiming for a purposeful sample of diverse, experienced clients who could comment on the services, rather than a randomly selected representative group of clients (Patton 1990). Additionally, services were asked to recruit clients to represent as broadly as possible the groups, programs, and services at each site, and to aim for variance in age and gender, which may have partially mitigated the potential for selection bias. At one site (Congress) a selection of 60 clients compiled by key workers were posted invitations due to a low success rate with the practitioner-led invitations. This yielded 10 registrations across 2 workshops, with 6 attending (10% response rate).

[Insert Table 3 here]

The workshops took three hours to complete. Catering, including lunch, was provided at each workshop. Participants were reimbursed with a \$30 gift voucher, and offered assistance with transport. A small number of clients were provided with cab charge vouchers, petrol reimbursement for long commutes, or bus tickets upon request. The state managed Aboriginal Health Team arranged a bus to transport all participants to and from the workshop. Child care for the duration of the workshop was arranged through the health service for participants with young children.

### **Achievement of the workshop aims**

The workshops demonstrated advantages over more traditional client survey methods in terms of the four aims outlined above.

## 1. Inclusivity

Traditional surveying methods – such as pen and paper questionnaires or web surveys often attract lower rates of response from some population groups, especially those with low socioeconomic status, and those with poorer health (Stoop 2005, Galea & Tracy 2007).

Such standard evaluation methods may not necessarily support inclusion of users from “hard to reach” populations and may raise barriers to participation, such as lack of English language literacy or the cultural inappropriateness of the method or instrument. The workshop was designed to overcome these barriers. As well as the transport and child care support, the other main strategy for reducing barriers to participation was to design the workshop so that no written literacy was required. All definitions and statements were read out and participants were only asked to contribute to a verbal discussion, yet quantitative data were still able to be generated through the selection of ranked statements for each service quality. Two of the pilot participants were migrants with limited English. The process was judged to succeed in being inclusive for these participants, as they contributed substantially to discussions in a way that indicated their comfort and understanding of proceedings. Interpreters were offered for all workshops, but no participants took up this offer. Asking for volunteers to read statements proved an effective strategy for encouraging all members to participate in discussion, as it provided opportunities for volunteering members to add their comments after reading their statements, and prevented discussion from being dominated by only a few voices. Checking for consensus on each statement also enabled facilitators to seek opinions from quieter participants.

We achieved a good range of ages, and both males and females participated. However, at the four non-Aboriginal specific services cultural diversity was limited, with no Aboriginal clients and few newly arrived migrant clients participating. One service reported that racism was an issue in the local community, and were reluctant to recruit newly arrived migrant or Aboriginal and Torres Strait Islander clients for fear they would experience racism in the workshop. As a result, the research team implemented protocols outlining how they would

deal with any racism arising in the workshops, which included inclusion of an Aboriginal and/or a recent (Iranian) migrant as workshop facilitators, challenging any discriminatory viewpoints as they arose, debriefing with any participants who experienced any discrimination or discomfort, and having a worker from the service available after the workshop in case of any distress or concern. This was particularly seen as a risk with the inclusion of the service quality 'culturally respectful.' In two of the workshops, discriminatory viewpoints were aired and needed to be addressed, even though there were no participants in the group who identified themselves as a migrant or Aboriginal or Torres Strait Islander. The following is an example of the type of exchange that needed to be carefully managed:

*“Participant (P) 1: That annoys me because being a white Australian they seem to pander to other races more than the white Australians and we’re the ones that are original - well apart from the Aboriginal people.*

*P2: That's what I was going to say - be careful what you say there.*

*Facilitator (F) 1: Well this says all cultures. So that will include yourselves, we all have a culture. I lived in Indonesia for a couple of years and boy was I aware that I had a different culture from the people that I was living with.*

*P1: That's my point we go to their country we know what laws not to break and whatever, they come here and they don't care what our laws are.*

*F1: Well I don't know that I agree with that.*

*P3: We're getting political.*

*F1: We are getting political.”*

The exchange highlights both of Kitzinger's (1994) suggested strategies to mitigate racist or heterosexist comments – firstly, to use dissent in the group to challenge these attitudes (P2 and P3's comments show the scope for this approach), and secondly, to intervene to move the discussion along, as seen in P3 and F1's rounding up of the discussion.

Recruitment was problematic at two services. Two workshops at the sexual health service, SHine SA, were cancelled and one suffered low attendance (2 participants). We ascribed this to a number of factors:

1. Sexual health is often a very private issue, and people may not have been willing to discuss aspects of their service use in a group situation (though see Kitzinger 1994, Farquhar & Das 1999 for counterarguments to this).
2. Setting a specific time and date to attend a workshop is problematic for some clients given the circumstances of their lives. This is reflected in the service's flexible approach to appointments and a high rate of non-attendance for normal appointments.
3. Compared to other participating services, SHine SA reported typically seeing clients for shorter periods of time, and with more irregularity. Firstly, this may have meant staff had less opportunity to establish the kind of relationship with clients that would encourage their attendance at an evaluation workshop. Secondly, clients may have been less likely to feel sufficiently knowledgeable and experienced with the service to meaningfully participate.

Similarly, three workshops at one of the Aboriginal services (Congress) were cancelled due to lack of participants. Three other workshops at Congress were successfully conducted with between three and seven participants. The workshop with the state-managed Aboriginal Health Team was also a success, with eight participants attending. Similar to SHine SA, a significant barrier for Aboriginal clients may have been the need for a particular date and time to attend – competing priorities, illness and personal circumstances, and cultural factors may have prohibited attendance for many clients. The Aboriginal Health Team's provision of transport is likely to have been a significant contributor to the good attendance rate. No Congress clients took up the offer of transport. Additionally, Congress stakeholders suggested the Aboriginal community in Central Australia felt over-researched and over-burdened with participation in other community meetings. Participants who attended the

workshops at the Aboriginal health services provided very positive feedback about the process. One participant praised the group process, saying “*like today, I think can be a really good thing. From young fellas to the Elders.*”

An alternative to convening workshops at a specific time and date is to take advantage of pre-existing groups, by running the workshop as an extension of scheduled group sessions (eg regular cultural or health promotion groups). However, there were concerns that extending an existing group session by three hours may tire participants and not be conducive to collection of rich, useful data. Using an existing group would also mean less variance in who attends (in terms of age, gender, health situation, or other demographics, or coverage of the programs and branches of the health service).

## **2. Comprehensiveness**

Comprehensiveness was sought in terms of the ratings and discussion representing the whole of the health service. Most evaluation of Comprehensive PHC has focused on “slices” or specific programs, rather than look at a whole of service (Hurley *et al.* 2010). Hence, for these community assessments, it was vital to get as comprehensive a coverage as possible of all the different services and programs provided by the site. At most sites, recruitment was stratified to request a number of clients from each team in the service, and workshop participants had used a variety of the services on offer. For example, at one of the state managed PHC service workshops, the following services had been accessed by at least one participant: early childhood services, including speech pathology, “SPOT” (speech pathology / occupational therapy) groups, and psychology, a depression support group, counseling, a lifestyle advice program, domestic violence group, nutrition, dietetics, social work, and a women’s group. The group discussion allowed the final rating to be informed by perspectives on all these different aspects of the service, and participants tended to take account of

everyone's experiences when deliberating on statements. This provided a useful alternative approach compared to aggregating or exploring individual scores on a survey. While there are benefits associated with both approaches, the workshop allowed direct, nuanced discussion of the reasons for different experiences with different aspects of the service, and identified commonalities between different people's experiences.

Providing both ratings and qualitative data allowed a snapshot of how the health service was performing against the nine service qualities, as well as in depth information on the strengths and weaknesses of the health service's performance. The quantitative ratings were presented in spidergrams (see Figure 1 for an example spidergram from one of the workshops), a visual representation method found to be successful in conveying quantitative data, and allowing changes to be mapped over time, in a range of different settings and cultural groups (Laverack 2005). One of the authors (RL) used this technique in an evaluation of a community-based physical activity promotion program. The program's enhancement of community capacity was assessed and mapped over a two year interval, with differences in the spidergrams used to inform changes in program direction (Chad *et al.* 2005). These spidergrams were presented to services to illustrate how users had rated the different service qualities for that service.

[Insert Figure 1 about here]

### **3. Rich Descriptiveness**

The dynamic nature of the group process meant participants sought clarification from other participants, challenged views, and added to others' comments. Such participant interaction (rather than facilitator intervention) resulted in richer data than would have been provided by a more individual-focused method. We found for the Aboriginal-specific workshops, this particularly fit well with cultural traditions of storytelling (yarning), where participants could relate stories and build on each others' stories in describing their experience of service qualities (Bessarab & Ng'andu 2010). The following example shows a group coming to a

consensus on how responsive the health service was to the local community. Participants challenged each other and took multiple factors into account before choosing a rating:

*"P1 (Female): No, I don't think it goes out of its way because where's the men's group? That's a whole 50% of the population that's been cut off right there, if they've got nothing except one male counsellor to help how many men in this area? So it's got to be somewhere between these three here that says they are listening but they're trying to make changes.*

*P2: You can't really make a generalised statement, like you can't say, yes, this is right, because there's examples here just in this group alone where needs aren't being met.*

*P3: I mean, it makes changes but I think it's --*

*P5: Within the restrictions.*

*P3: It's within its own restrictions because they can't - there are certain things they can't do.*

*P5: Well, in that case then it does things to change the way it works to better meet these needs. So when they find out something that's needed then they change it to better meet the community's needs.*

*P1: Well, have they? How long has there not been a men's group?"*

Generally, facilitator intervention was not required to reach consensus. When there was disagreement among participants, it concerned two adjacent statements (e.g., statements 3 and 4). If no consensus was reached, the facilitator would propose accepting both statements, and would rate the service at the average of the two (in this example, 3.5). In some cases, participants suggested alternative wording, or combined wording from two adjacent statements in order to reach consensus (again, leading to an averaged rating). In the example quoted above, the group altered a statement thus:

“The service asks and listens to what the community needs. When it is made aware of what the community needs it usually makes an effort to change what it can to meet these needs better *within its set constraints*”

Analysis of the workshop transcripts allowed the researchers to produce detailed reports outlining why clients rated the health service as they did, and suggestions to improve the service's score. For example, in one report we were able to provide detailed requests on the size, duration, timing, structure, and location of group sessions to better enable clients to receive ongoing benefits from the groups. Feedback from services indicated this detail was more useful for service delivery improvement than the ratings alone. For example, while services were rated highly on reaching those most in need, considerable feedback was provided on issues such as transport availability, integration with other services, accessibility of crèche services, and access for those with physical disabilities that could highlight areas where the service could act to improve access. While open ended questions can be included in pen and paper surveys, research indicates these are not commonly filled out (Dillman *et al.* 2002), and are unlikely to have as much detail as verbal discussion allows.

#### **4. Empowering**

Empowerment is the improvement in capacity, power, or control for an individual or collective (Rifkin 2003, Lavarack & Labonte 2008). A core principle of PHC is that it aims to enable the empowerment of individuals and the community to support people's control over their own health (World Health Organization 1978). The method was adapted from Laverack's community capacity workshops, which draws on empowerment evaluation and participatory evaluation (Brunner & Guzman 1989) frameworks to study and enhance program contributions to community empowerment, and to be in itself an empowering process (Labonte & Laverack 2001). A criticism of more traditional client surveys is that they offer little opportunity for empowerment, and may be disempowering if clients expect changes in service delivery that often do not eventuate. It was therefore important that the method sought to enable some level of empowerment for participants, or at worst not to lead to a

sense of disempowerment for those who participated. This was especially the case for the Aboriginal specific workshops, given the history of over-research of Aboriginal and Torres Strait Islander peoples, and the typical lack of feedback and change arising from research (Brands & Gooda 2006, Johnstone 2007). As one Aboriginal participant reflected:

*“Listen to what we are saying too that we’ve been there and done that, and what we’re saying today is what we said 30 – 40 years ago.”*

Evaluation research is increasingly acknowledging the need for evaluation efforts that involve Indigenous peoples to provide them with more control over all aspects of the research process (Kerr 2006, Anderson *et al.* 2012), and to challenge the imbalanced power relationships that accompany ongoing processes of colonisation (Smith 1999, Sherwood 2010). In this way evaluation research can contribute to social change and the process of ‘decolonisation’ (Smith 1999, Sherwood 2010) Our study was based on research partnerships with Aboriginal health services, and included Aboriginal investigators who contributed to the research design, and Aboriginal researchers employed on the research who contributed to workshop facilitation, analysis, and write up.

The main strategy designed to give participants more control was the feedback loop whereby all participants were invited to provide an email or postal address to receive a copy of the report that was sent to health services. A letter responding to some of the feedback provided in the workshops was requested from and provided by service managers, which could then be mailed to participants along with the final report. This provided both an opportunity for participants to make any corrections to the researchers’ reporting of the workshop, and also an indication of the service’s response to their feedback, and what changes they might expect.

In addition, attention was paid to participants’ knowledge of their rights when accessing health care, and in two workshops the right to submit a complaint was discussed (both pertaining to health services other than the PHC services being reviewed). One participant reported this as being empowering:

*“I reckon like today is the first time I’ve been approached that I can actually put in a complaint. I didn’t know who to go to before”*

Participants reported a number of incidental benefits to participating specific to a group setting. Participants often learned about different programs the services had on offer from other participants, with one participant reporting: *“I learnt about a lot of extra services today that I wasn’t even aware were available.”*

Participants also spent some time swapping advice and tips on other services or benefits, such as when one participant reported having to cancel their internet subscription when moving onto a disability pension:

*“P1: The library often has free internet too.*

*P2: Yeah but that’s only for an hour, it takes me an hour sometimes just to find something.*

*P3: There’s community clubs that have them too ... on [road] there’s an old church ... and they’ve got 10 computers or something there that you can go and use for free.*

*P4: You can go through [businesses] they’ve got very good rates for pensioners, have you tried them?”*

Participants also indicated deriving benefit from social interaction in the group, and of having a sense of a community voice, with some participants exchanging phone numbers after groups either to catch up or to discuss issues raised in the workshop. For example, mothers in one group discussed options for advocacy around the closure of a parent help line, while participants in another group explored options for convening a general community support group to replace groups closed by the service. These benefits meant that the method may be more likely to give participants more control, building a sense of ‘community’ and collective action as compared to individual methods such as pen and paper surveys. However, this is not to assert that such group evaluations have the same benefits as empowerment specific approaches such as community capacity building.

## **Alternative group methods**

Other group methods were considered. The widely used Delphi method is similar in that it generates collective rankings, but does so without convening experts as a group (de Meyrick & Meyrick 2003), which we found valuable for the research and for participants. Delphi methods also typically rely on participants completing questionnaires and digesting considerable written information that may require a high level of literacy. The anonymity may, however, be valuable in some circumstances, such as for sexual health services, where we experienced difficulties recruiting participants for a group method. Avoiding the need to schedule participation at a particular date, time, and venue may avoid some of the barriers for individuals who find it difficult to attend such scheduled workshops. Nominal group technique has been applied to health service evaluation, such as the identification of service needs and issues with service delivery for specific groups (Potter *et al.* 2004). However, the method is designed to produce solutions to a problem, and then rank those solutions. While this may generate useful information around changes clients would like to see at health services, our workshop method combined this type of information with ratings of the service.

## **Conclusion**

The workshop method presented here aimed to be more inclusive, comprehensive, descriptive, and empowering than more traditional client survey methods. The workshops were able to capture the complexity of the health service in a comprehensive manner, providing a detailed evaluation of the service's achievement of the service qualities. The success of the workshops lends support to the robustness of the core processes adapted from Laverack's community capacity workshops, suggesting this form of group discussion and ranking is an effective means of gaining evaluations and viewpoints from community members. While these workshops focused on primary health care services, the method could be adapted to evaluate other health or social services by changing the service qualities and associated statements. Recruitment of service users, particularly those from culturally diverse backgrounds, remains one of the key challenges facing evaluators, and

this may be made more difficult for group workshops with set dates and times. However, we found the participants and the research benefited from the group approach, and that the workshops provided valuable, actionable information to the health services.

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### **Supporting Material**

Rating Statements for Each Service Quality Used in the Community Assessment Workshops

Figure 1. Example spidergram of ratings for the nine service qualities generated at one of the service workshops.

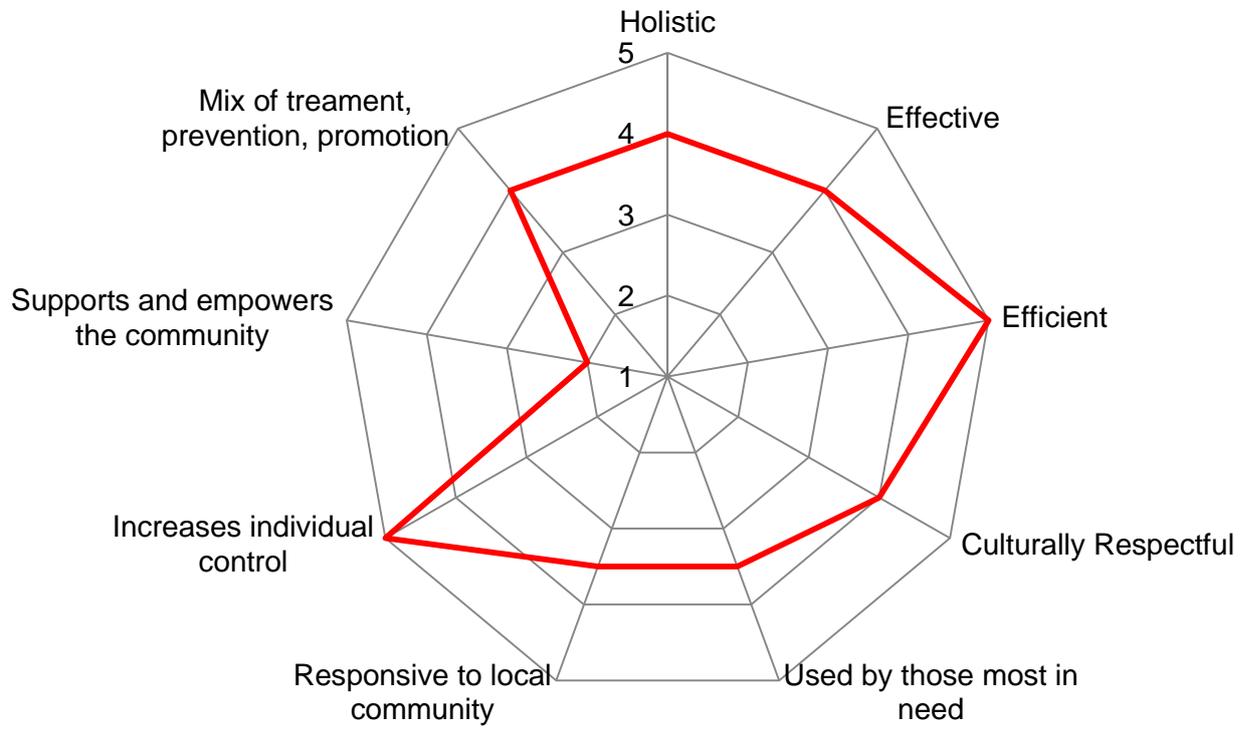


Table 1

PHC Service qualities examined in the workshops, and the lay definitions used

Service quality	Lay definition
Holistic	The service treats clients as whole people rather than just treating their health problems. They understand the pressures of daily life and try to offer a range of different ways of helping.
Effective	The service makes a difference to the health of the community. It provides useful, effective services that improve people's health. If it closed down, people's health would be worse.
Efficient	The service seems to use its resources wisely. It is well organised.
Culturally respectful	The service values and respects all cultures. People from all cultures would feel safe from prejudice, racism or bad treatment here. The service works in ways that best match people's culture.
Used by those most in need	<p>People have different levels of need for health care. Often the people who need health care the most are the ones who find it the most difficult to get health care. Perhaps because they don't have transport, they don't have much money, they don't know what services are available, or they're not confident in how to get the health care they need. Health services have to really try to support those most in need to be able to come and use their service.</p> <p>A service that wants to reach those most in need might really try to be welcoming and friendly, offer lots of assistance with completing forms and making appointments, provide health materials in different languages, offer good transport options, and usually have staff and appointments available.</p>
Responsive to the	The service is always asking the community and listening to the

local community	community to find out what they want and need to be healthy. The service tries to change what they are doing to better meet those needs.
Increases individual control	The service helps people to understand and take more control over decisions and actions affecting their health. They don't tell people what to do, but find out what is important to people, and discuss different options. They explain things like procedures, tests, and results well. People using the service feel informed and in control.
Supports and empowers the community	The service supports the community to gain greater control and ability to make their community a healthy place to live. It works with groups of people to tackle health problems in the community, to improve quality of life, or to change things that do not support health. For example, a health service might support a residents association to advocate to improve the safety of a local playground.
Mix of treatment, prevention, and promotion	<p>There are three things here. Treatment: the service treats people who already have a health problem – such as an illness, injury, stress, or mental health problem.</p> <p>Prevention: the service also helps prevent poor health – people who are at risk of becoming unhealthy might be more able to stay healthy and not develop a problem. Eg helps people to achieve a healthy weight</p> <p>Promotion: service helps people to stay healthy. It works to improve people's health and quality of life in general. It helps make the community a healthy place to live. Eg runs a new parent's group, men's shed</p> <p>A service that has a good mix would be good at all three of these.</p>

Table 2

Example set of five statements and corresponding rating for the holistic service quality

Statement	Rating
The service is only concerned about treating the immediate health problem	1
The service tries to understand people and the best way to treat their immediate health problem.	2
The service tries to understand people and helps them with their immediate health problem and any other health concerns they bring.	3
The service understands and treats clients like whole people and tries to do what works best for each person to help with any health concerns.	4
The service understands and treats clients like whole people. It tries to do what works best for each person to help with any problems - including things outside of health care, like money and housing.	5

Table 3

Number of participants at each workshop

Workshop	Males	Females	Total
Service A	3	7	10
Service B	1	7	8
Service C	3	7	10
Service D (Aboriginal Health Team)	6	2	8
SHine SA Workshop #1	0	2	2
Workshop #2	1	5	6
Workshop #3	3	5	8
Congress Workshop #1	2	5	7
Workshop #2	0	3	3
Workshop #3	1	2	3
<b>Total</b>	<b>20</b>	<b>45</b>	<b>65</b>