Assessing and serving families and communities responsibly: challenges posed in an urban, marginalised setting

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Abstract

Service provision to families and communities has long been recognised as a complex undertaking involving a multiplicity of role players and systems of care. Systems theory and ecological theory provide useful frameworks for understanding and servicing families and communities, yet there is a clear absence of literature and research on how to converge microsystemic with macrosystemic interventions.

Using Rojano's[1] community family therapy model, which is applicable to South American communities, and Kasiram and Oliphant's[2] strategies for changing traditional family therapy to suit broader contexts in South Africa, the authors used developmental research within a qualitative framework to develop an indigenous community family therapy model in an urban setting in KwaZulu-Natal, South Africa. The authors utilised nursing students as fieldworkers and service providers in this study. The research process involved several steps: a state-of-the-art review of the family and community, achieved through an assessment of the family and community through community profiling and an epidemiological study of the community; family assessment of families with one child under the age of five years; best practice and model development to intervene at the family and community levels, achieved with the help of community and school meetings and workshops to identify and prioritise needs and problems, followed by bio-psychosocial interventions; refining the model achieved by an evaluation of the interventions through report assessment and on-site assessment and recommending model adjustments based on the evaluation.

In designing a community family therapy model, the state-of-the-art review of community needs established several core issues requiring services/interventions. These were problems relating to HIV/AIDS; a lack of knowledge of the immunisation programme in South Africa and of the Road to Health chart; teenage pregnancy and its relationship to risky behaviours, HIV/AIDS, poverty and crime; and a lack of communication within the family.
The development of the model involved determining interventions with families and the community, using macrosystemic approaches, such as community meetings and workshops, where priorities were established and joint strategies were planned to address the identified problems. Individual and small-group discussions enriched the understanding of problems/needs, which, combined with macrosystemic approaches such as media coverage and community meetings and workshop/events, worked in synchrony to effectively assess and then service the families and communities. The goal of developing a community family therapy model was achieved.

Combining microsystemic and macrosystemic approaches to assess and serve families and communities is particularly helpful in the face of apathy. However, once momentum is achieved in securing a community spirit, it needs to be sustained or else it is lost and may require more effort to reclaim in the future. Thus, if services are provided by educational institutions, it would be in the best interests of both future students and the community if there is funding to support service outside of the academic year.

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INTRODUCTION

In proposing a community family therapy model for the South American context, Rojano steps outside of the traditional therapeutic box by combining family therapy techniques with developmental and motivational theories, community mental health, social work, economic development, and community mobilisation strategies.[1] Family therapy needs to extend its boundaries from the individual therapy setting to include families in a community, along with systems that have not been previously included in traditional family therapy, such as the spiritual system, dance and drama, and nature and nurturer.[2,3] Recent presentations by Kasiram and Khoza, Tome and Prosky at the 15th International Family Therapy Conference confirm this trend.[4,5,6]

Undergraduate nursing students at the School of Nursing of the University of KwaZulu-Natal, South Africa are required to take a year-long module in "Health Promotion and Illness Prevention". To this end, they conduct community development projects, which include the following phases and functions:
- Assessment of a community through community profiles
- An epidemiological study of the community
- Family assessment of a family with one child under the age of five years

- Health interventions in the community
- Evaluation and termination of the community partnership

These phases form a useful research frame and are in accord with the developmental research design that was the primary research method employed by the authors.

The project was undertaken in the Point area of Durban, KwaZulu-Natal (KZN), South Africa, an urban area renowned for its crime, poverty, prostitution and immigrant population. There are about 650 households in the area.[7] However, the exact locale where the students work is pre-selected so as not to jeopardise their safety. It therefore does not have the same high levels of crime as the rest of the area. Nevertheless, core features of a deprived neighbourhood feature prominently, challenging service providers to work "outside the box".

RESEARCH METHODOLOGY

The overall aim of the study was to develop a community family therapy model to offer comprehensive services to a selected group of families in the Point area of KZN by combining family therapy approaches (microsystemic) with community development strategies (macrosystemic).

The objectives of the study, as derived from this aim, were as follows:
- To review family and community needs and problems to appreciate the multi-systemic dynamics of an urban, marginalised neighbourhood.
- To plan and implement service interventions based on the review.
- To evaluate the interventions with a view to developing best practice models for future implementation in similar settings.
- To effectively combine microsystemic and macrosystemic approaches in the process of model development.

The study followed a qualitative framework, with a developmental focus.[8] The phases of a developmental research design were followed via a carefully designed research process. These phases are in synchrony with the aforementioned aims and objectives, namely:

1. State-of-the-art review
This was achieved by entering and assessing the community according to its health, social and psychological needs against resources in the community. To achieve this, a community meeting was held at the local pre-primary school, where families were willing to be interviewed over three to four sessions to supply information and receive professional assistance.

2. Validating the review
A further community meeting was held to validate findings from the family interviews and to prioritise the problem areas in the community.

3. Planning intervention for model development
Community interventions were suggested in class group discussions after a critical review of the community profile had been undertaken. Community and school meetings were held to obtain community input on identified interventions in the community and to invite families to participate in the interventions.[9]

4. Implementation
Interventions were executed using both microsystemic and macrosystemic approaches.

5. Evaluation and refinement for model development
Interventions were evaluated through a critical analysis of reflections, reports and on-site visits and best practice for the recommended community family therapy model.

Sample
The research was limited to pre-selected areas in the Point area of KZN. A total of 13 families from the pre-primary school were selected by **convenience sampling**[10] to participate in the project, with the school providing access to families in the community.

Data collection and analysis
Data was secured from the students' family interview reports, community profile reports, community meetings, class discussions and on-site observation of interventions. Triangulation was thus evident in securing more than one data source for this project/study.[11] The data analysis strategy included inductive reasoning and scrutinising data to establish relationships or patterns.

Ethical considerations
Ethical clearance to conduct the study was obtained from the University of Kwa-Zulu-Natal. This meant that confidentiality and anonymity were respected when the families were interviewed and no names were used during reporting in the profiling stage when the data was gathered. The researchers also secured the permission of the families to participate in the study. The families were informed that they were at liberty to withdraw at any stage. No one availed themselves of this opportunity.

As it is unethical to simply glean information on people's problems without providing a service, the intervention stage involved service provision by the fieldworkers (students). This service was painstakingly supervised and monitored individually by the authors and via the student group during group class consultations. The latter ensured best practice and served the objectives of the study.

RESULTS AND DISCUSSION

1. State-of-the-art review
The information gleaned from the family assessments was rich and provided the following in-depth information on family problems and needs:

Family profiles
Of the 13 families interviewed, 11 had more than two children and one family comprised 13 members. Only two families were headed by a single parent, with the remainder having both parents. The families were characterised by mobility, as several had recently moved into the area in search of stability and employment because the area is home to the newly developed Ushaka Marine World, which offers employment and other benefits.[12,13]

Housing
All the families lived in well maintained but cramped flats that had strict security control at the entrance, while some had maids to take care of the children and the home. Flats were accessible to amenities such as shops, health centres and entertainment centres.

Substance use
The families expressed concern about the large-scale drug trafficking in the area, with some being personally affected. A mother suffered physical abuse because of substance dependence and another indicated that both her adult children abused substances. One

family's fridge was well stocked with alcoholic beverages, but contained no milk, even though there was an infant in the home.

Safety, security and crime

Security at flat entrances was common because of criminal activity, such as murder, robbery, drugs, domestic violence and prostitution, in the vicinity. One mother kept her children indoors all the time; unhealthy and frustrating, but considered necessary! Families lived opposite taverns, pawn shops, liquor stores and sites of prostitution activity.

2. Prioritising problems and planning interventions

The following problems and interventions were prioritised using family interviews and community meeting reports, class discussions and on-site visits:

Problems relating to HIV/AIDS

This was established as a key problem.

Intervention

The pre-primary school invited the nursing students to take part in their workshop to develop a policy for dealing with the specific needs of children living with HIV/AIDS. The policy included guidelines on respectful and helpful conduct of staff toward children and parents living with HIV/AIDS; healthy eating habits and the provision of healthy lunch boxes; and how to deal with small cuts and injuries in the preschool setting. The ease with which this task was undertaken was attributable to the relationships that had been built and that were nurtured via individual and small-group meetings between the families and educators. Thus, using microsystemic approaches in policy formulation was clearly helpful in taking ownership of the problem and determining strategies to engage meaningfully with it.

Lack of knowledge on the immunisation programme in South Africa and the Road to Health chart

During the assessment of the families, it was found that many were unsure about the importance of immunisation.

Intervention

Students offered their services by manning an information table at the pre-primary school's "fun day". As the community is fairly closed and difficult to enter, the school provided "legitimate" entrance to convey this message. Since

attendance at this function was excellent, many community members were served through information booklets and by providing answers to questions. Referral to the local primary healthcare clinic was done for families in need of its services. Accessing existing resources (in this case the school) from the students' community profile was key to the success of knowledge acquisition among community members. Careful assessment may thus be seen to enhance the selection of appropriate resources in addressing needs. The relationship with the school was actively nurtured by previous student groups, as well as by the present group, to ensure optimal benefits for the community regarding education and preventive health care.

Teenage pregnancy and its relationship to risky behaviours, HIV/AIDS, poverty and crime

At the community meeting, the parents identified teenage pregnancy as a serious problem.

Intervention

A workshop was conducted at the local primary school on the effects of teenage pregnancy on the individual and the family. The workshop was attended by senior children from the school, as well as by community members and parents. Methods of family planning and safe sex were addressed and information booklets were distributed. Attendance at this workshop could have been better if the microsystemic contacts that had been secured with individuals and small groups in the community been accessed differently, e.g. further individual contacts to advertise the workshop; use of community members themselves in advertising; and media coverage. However, the project is fairly new and the lessons learnt here ought to benefit the project in the future.

Lack of communication within the family

In the family assessments, as well as in the community meetings, lack of communication within the family was viewed as a major problem. Parents worked long hours and did not enjoy open communication with their children. They had lost out to friends in this regard. The influence of friends in perpetuating myths was accepted as potentially harmful.

Parents also wanted to know how to manage conflict within the family.

Intervention

A workshop was held at the primary school on the importance of communication and those attending were taught how to communicate with I-messages and listening skills. The day's events concluded with fun and a prize giving to exemplify that communication leads to easy and good relations. The macrosystemic focus of identifying a joint concern was empowering for the community. Had it been possible to tap the energy produced from the workshop immediately, it would have saved future students from having to re-establish contact afresh the following year. However, the reality is that this project depends on students who are used during University term time, there is no funding to continue outside of these times and thus it was not possible to keep the momentum going. A further criticism is that the students did not offer individual guidance/assistance to supplement or complement the community-based intervention. This could be attributable to a lack of skills and/or absence of a dedicated team of professionals serving the needs of people in the Point area.

3. Recommendations for a community family therapy model

Murry and Brody.[14] and Muir et al.[15] offer the following advice in setting up a community family therapy model to effectively serve the social and health needs of families and communities:

- *Engaging with individual families, a microsystemic contact* that fuels macrosystemic, successful interventions, as it allows not only a thorough understanding of family problems, but also provides for relationship-building, which was essential in this community, given that no community spirit prevailed.
- *Offering family therapy together with community-based intervention:* this was seen as essential in deepening trust, and to further the goals of the project. Both interventions work hand in hand to complement and supplement each other so that the end product is a community comprised of families that have all been heard and had their individual and group aspirations addressed.
- *Partnering with the community via*

focus group discussions: these meetings allow for the validation of findings and for prioritising so that individual agendas are given a community voice.

- Working with *healthcare, educational and justice systems and engaging women* on issues affecting them. This assures the comprehensive engagement of all stakeholders and sustainability. In the Point project, only the school, church and healthcare systems were accessed. Had more stakeholders been involved, the project could have been more inclusive, comprehensive, effective and better supported. Also, individual connection would have supported stakeholder commitment to the project goals, suggesting the importance of combining both levels of intervention throughout the project.

- *Having monetary and non-monetary incentives for participation* to affirm the families' time as being valuable: refreshments, lunch and prizes served as incentives to affirm participants and to convey an understanding of individual and community hardship, especially relating to finances. Appreciating individual realities contributes to the commitment by service providers to make available such incentives, as these may not be heard when the target is a larger group. Since financial problems were found to be less serious than the need for shared spirit and fun in the Point project, incentives centred around sharing through food, refreshment and prizes.

- *Informing and advertising through a newsletter, newspaper articles or mass media* such as television to highlight community interests, goals, programmes and progress: the authors, together with the students, published two reports on the programme activities in the local newspaper. The need was for "advertising" what was happening, to build the community and to increase participation. At the individual contact level, families were made aware of needs, problems and possible interventions, but, unless the community speaks, priorities cannot be established and interventions cannot be owned. Advertising in this way brings home the message to unite and share in problem identification and resolution.

- The need for *cultural sensitivity and appreciation of a context* of daily hardship/realities: the authors unreservedly accept this need. The family or community should never be judged, especially when they are too ashamed to own their neighbourhoods, as this stifles any efforts to stimulate interest in change.

- *Nurturing the partnership* so that, at the end of the year it is not halted because of the unavailability of students. This is important to note, as people feel used when they are dropped when the agendas of service providers are satisfied. Such feelings would frustrate future efforts and the University is cautioned about developing short-term relationships that prejudice communities.

- *Students/service providers should offer family therapy themselves or refer to appropriate specialists* so that both the community-based interventions and individualised family assistance complement and supplement services.

CHALLENGES

Entering this community was a tremendous challenge, as no community spirit/ camaraderie/ togetherness existed. In fact, one can safely say that this community resisted the notion of being seen as one, and this challenge was exacerbated by the movement and fluidity of membership in the community. Related was the challenge posed by the fact that the families did not know people in the community, not did they believe they needed each other. This made bringing them together difficult but not impossible. A key frustration was achieving growth, and not having resources (funding and person power) to continue to build on the successes.

RECOMMENDATIONS

Recommendations for model refinement were indicated through the conduct of this study. These recommendations are listed below:

Thorough engagement with individual families, a microsystemic contact to fuel the development and impact of macrosystemic interventions; partnering with the community via focus group discussions and meetings to validate findings and prioritise so that individual agendas are given a community voice; working with healthcare, educational and justice systems and engaging women on issues affecting them to assure the comprehensive engagement of all stakeholders and sustainability;

providing monetary and non-monetary incentives for participation to affirm families' time and effort as being valuable; informing and advertising through newsletters, newspaper articles or mass media such as television, to highlight community interests, goals, programme interventions and progress to build the community and to increase participation; cultural sensitivity and appreciation of a context of daily hardship/realities and never judging, or else the service is doomed before it begins; nurturing the continuity of the partnership so that, at the end of the year, it is not halted because of the unavailability of students; training students to offer family therapy alongside community-based interventions to complement and supplement services.

CONCLUDING REMARKS

Dominelli[16] and Ife and Fiske[17] advise, and we agree, that success and sustainability in work with communities requires "commitment to working in egalitarian value systems, as well as holistic approaches to social, economic, physical and spiritual environments in which people carve out their daily lives".

The community family therapy model developed in this research highlights core ingredients of this statement, viz. sensitivity to context, non-judgementalism, engagement with all stakeholders and multiple systems and respecting daily hardships and realities. This article describes some efforts at networking in a "hard to reach" community, made possible by accessing individual families first. Without the support of this first step, which should continue throughout the project, the authors believe that the effectiveness of the programme and any progress made would be sabotaged.

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