

Notes from the Field

Submissions to Notes from the Field (500 to 1000 words, preferably without references, tables, or figures) should be sent to Hugh H. Tilson, MD, Editor, AJPH Notes from the Field, ESP Division, Burroughs Wellcome Co, 3030 Cornwallis Road, Research Triangle Park, NC 27709. This column presents information on newsworthy public health programs and project experiences at the community level. Guidelines for Contributors to Notes from the Field can be obtained from the Journal office. Further information about the articles published in this issue should be sought from the author(s) listed at the end of each article.

Using Race-Specific Community Programs to Increase Organ Donation among Blacks

In 1989, the Mid-America Transplant Association received funding to establish an education project for Blacks with the goal of increasing organ and tissue donation. The Association is an organ procurement organization based in St Louis, MO, that serves six transplant centers and a combined population of over 4 million people in eastern Missouri, southern Illinois, and northeastern Arkansas. The Association is one of 68 Medicare-approved not-for-profit organ procurement organizations serving vital organ transplant programs in the United States. Like other organ procurement organizations, the Mid-America Transplant Association has fewer minority than White organ/tissue donors. Eight percent of the population in this transplant region is Black, and 98% of all Blacks in the transplant region reside in the St Louis metropolitan area.

We describe a community intervention to increase the number of Black organ donors. A Black health educator recruited for the education project began outreach efforts for the Association with a focus on the public regional hospital, community health centers, and hospital clinics in the community. A 25-member community advisory board was established to foster communication, gather insight, and provide guidance for the project. This diverse group included Black medical professionals, community leaders, clergy, transplant recipients, and donor families. The community advisory board together with Association staff developed pamphlets and display materials targeted specifically toward the Black community. A "Black Issues in Transplantation" conference was held for health care professionals and served as a means to enlist the support of Black physicians and health care professionals.

In 1990 additional funding from the Division of Organ Transplantation, Health Resources and Services Administration, was received to extend the minority education project and to hire an additional Black staff member to serve as an organ educator/requestor for Black families. In addition, this individual was recruited to work with predominantly Black high schools in the St Louis area as part of the community education program.

Concurrently, a Black-owned public relations firm was engaged to facilitate contact with key Black organizations, individuals, and clergy to maximize exposure about organ donation on radio and television programs and in newspapers that had specifically Black audiences. A "Black Issues Symposium" was held at which special attention was given to ethical and religious issues in organ donation and transplantation.

All Black families of potential vital organ donors who live in the St Louis area

have been approached by one of the two Association Black educator/requestors beginning in 1990; the educator/requestors are still contacting new families. One of the two requestors is on call each week; the one not on call uses the time for the community education component. A donor family's consent is counted as a positive donation even if the actual donation becomes impossible because of medical exclusion criteria.

Comparison of referral rates and donor rates between candidates prior to the initiation of the programs (1988) and after several years of implementation (1991) demonstrates the effectiveness of our approach. The number of referrals of potential Black donors rose from 30 in 1988 to 69 in 1991, an increase of 130%. In contrast, White referrals increased from 123 in 1988 to 169 in 1991, a 28% increase. When we control for base population, using 1988 census information for all counties served by the Association, Blacks were referred at a rate of 9 per million population in 1988 while Whites were referred at a rate of 33 per million. By 1991 the rate for Black referrals had risen to 179 per million population, compared with the steady base rate of 32 per million for Whites. As a group, Blacks are more likely than Whites to be in the pool of potential donors and to be asked to donate vital organs. By 1991, as a result of the efforts of the two Black organ requestors, Blacks were more than four times as likely as Whites to be approached about potential organ donation.

Increases in Black referrals are resulting in increased conversion of potential donors to actual donors. After the community education programs were augmented by the addition of Black requestors, the percentage of Black donors rose. In 1988, 5 donors were Black, representing 7% of the total donor pool for this organ procurement region. By 1991, the ab-

solute number of Black donors increased to 16, accounting for 20% of the total donor population for the region served by the Association.

Despite the use of Black organ educators/requestors with potential Black donor families, the consent rate of Blacks did not equal the consent rate for Whites. In 1988, 54% (67/123) of all Whites who were referred for donation gave consent, while 16% (5/30) of referred Blacks consented to donation. Since the efforts of the Black organ educators/requestors began in 1991, the consent rate for Blacks has risen to 23% (16/69), while White rates declined to 38% (64/169).

It should be noted that not all hospital referrals automatically result in actual requests for organ donation. Many of these cases fail to meet brain death criteria or are subject to other medical exclusions. Therefore, the consent rates of some organ procurement organizations are higher because their rates are calculated on the basis of families who are actually approached rather than on the basis of families who are theoretically eligible for donation. In our data for 1991, using the actual approach method, the Black consent rate more than doubled to 38% (16/42), while the White consent rate remained essentially the same at 59% (64/108). Data for families actually approached in 1988 were not available to the Association.

This project required two full-time equivalent staff at an annual cost of less than \$100 000. Our preliminary data suggest that community education specifically designed for Black families and the use of Black organ requestors for Black families can increase the number and proportion of Black organ and tissue donors. Whether the education programs or the use of specific Black requestors separately or jointly accounted for the increased rate is not known. Further research will be needed to evaluate the effects of these two program components.

Consent rates for potential Black organ donor families are still below the rates for White families. However, this report shows that Blacks can change their opinion about organ and tissue donation and dispels the incorrect impression that consent rates cannot be improved for Black families. Black attitudes are not fixed in opposition to organ and tissue donation, and the use of Black organ educators/requestors may make substantial changes in rates of recruitment of potential donor families. The development of the program was the only system-wide change during

the time period studied. The Required Request Law, which requires hospitals to request organ and tissue donation from all potential donors, was enacted a number of years prior to this study and therefore cannot be an alternative explanation for the observed increase.

Our next step will be to conduct structured interviews with Black families, both those who consent and those who refuse to donate, to document the factors most important in the consent process. Studying the requesting process may add information to help improve minority participation rates in organ and tissue donation. Other culturally homogeneous groups may also be well served by this community approach to increasing organ and tissue donation. □

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Copies of materials used, including pamphlets, symposium agendas, and ads, are available from the authors.

Acknowledgment

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Clinica Tibas: A Public-Private Partnership for Health Care Delivery in Costa Rica

Historically, health care in Costa Rica has been provided by the government. Health promotion and disease prevention have been in the province of the Ministry of Health, and hospital and medical care have been under the aegis of the Social Security Bureau. Medical care in the private sector has been available to those who can afford it.

Recent criticism characterizes the public system of medical care as overly bureaucratic and inflexible, making sub-optimal use of resources, and restricting finances for the provision of services¹.

The Social Security Bureau has been described as fostering routine and apathetic medical care, failing to recognize local needs, and being narrowly focused on a biological concept of health and illness.² Consumer complaints cite long waits for service and treatment that is discourteous, impersonal, and at times detrimental to health. Ambulatory care is often sought from hospitals, adding to their burden and contributing to those conditions about which consumers complain.

Experimental Responses

Costa Rica's government has in recent years sponsored several experiments in health service delivery featuring contractual arrangements between the Social Security Bureau and the private sector. The first of these involved the formation of a "cooperative" to operate the Integrated Clinic at Pavas. In this context, a cooperative is an association of a variety of interests that stands to gain financially if it succeeds in providing services to an assigned population in an efficacious and efficient manner.

A more recently organized effort, described here, is that serving Tibas, a community of approximately 50 000 adjacent to San José, the capital of Costa Rica. Contractual arrangements with the Social Security Bureau convey responsibility for servicing this population to COOPESAIN R.L., a private entity composed of a full range of professional, technical, and administrative personnel. Many of these individuals were previously employed in the public sector.

The cooperative was legally constituted on July 2, 1989; the Integrated Clinic at Tibas was opened on January 31, 1990 with the full range of services available by May 2, 1990. The clinic is operated under the supervision of the Social Security Bureau and the Ministry of Health.

The Integrated Clinic at Tibas

This newest experiment in health service delivery retains those elements of the existing public system for health care that are desirable while introducing innovations aimed at increasing client and provider satisfaction and organizational efficiency. The stated goals of the cooperative are as follows²:

- To apply and fortify the strategy of primary health care, featuring a focus on the family and with emphases on health promotion and disease prevention.

available. Similarly, despite recognition that even modest resources can stimulate grassroots initiatives, few demonstrations of this leveraging process have been reported. This note describes the involvement of the Work Group on Health Promotion and Community Development at the University of Kansas in designing and implementing two innovations: a process for assessing community health concerns and a microgrants program to encourage self-help initiatives.

In January 1990, portions of the Concerns Report Method¹ were modified to identify strengths and problems in the community related to public health and alternatives for improvement. This process was implemented to identify the health concerns of low-income people in Lawrence, Kan (population 65 608), and surrounding Douglas County (population 81 798). This was the first application of the Concerns Report Method to assess community health concerns.

The Concerns Report Method involves several steps. First, members of a consumer working group—in this case, low-income clients of local health and human service agencies—review a menu of potential issues (e.g., availability of affordable medical and dental treatment). The working group selects, adapts, or creates approximately 30 items to appear on a unique concerns survey. Item categories currently include acquired immunodeficiency syndrome (AIDS) and sexually transmitted diseases, alcohol and substance abuse, adolescent pregnancy, cancer, cardiovascular disease, injury prevention, mother and child health, smoking and tobacco use, basic health issues, and domestic violence. For example, one item related to substance abuse reads: “programs to help people quit smoking are available and affordable.” The selected items form a self-administered questionnaire which is set at approximately a fifth-grade reading level.

Second, the questionnaires are distributed through local health and human service agencies. Respondents rate each item on its importance and their satisfaction with it. A formula is used to report percentage importance and percentage satisfaction. Items rated high in both importance and satisfaction are considered relative strengths; those high in importance and low in satisfaction, relative problems. Third, the questionnaire responses are compiled and analyzed and a report of the findings is prepared and distributed to health and human service agencies, city officials, and other interested or-

ganizations. Finally, a public meeting is held to discuss identified strengths and problems and generate alternatives.

In this application of the Concerns Report Method, we collaborated with representatives of local human service agencies and organizations. Participants included representatives from the local United Way agency, the county health department, local poverty agencies, an agency serving people with disabilities, the county AIDS task force, an organization working on the prevention and treatment of drug and alcohol abuse, the Council on Aging, the local women’s shelter, and the local Visiting Nurses Association. Participants had an interest in specific health issues (e.g., drug and alcohol abuse, adolescent pregnancy, or AIDS), contact with low-income persons, or both. This group—calling itself the Douglas County Coalition on Community Health Concerns—agreed to sponsor a survey to assess the strengths and problems of the county related to community health.

The survey of community health concerns was a volunteer effort. Representatives of the Douglas County Coalition on Community Health Concerns donated their time and resources to photocopy and distribute the survey. Staff at the Work Group collected the surveys, analyzed the data, and prepared and distributed the final report free of charge (the report normally costs approximately 50 cents per completed questionnaire).

The survey was distributed through local health and human service agencies and during distribution days for commodity food programs and the county health department’s Women, Infants, and Children Program. Agency representatives and staff from the Work Group invited people to complete the survey. Approximately 300 people completed the survey (the actual response rate is unavailable). The majority of respondents were women with household incomes of less than \$10 000 a year. Most respondents were working poor, reporting at least some earnings from jobs.

Major problems identified by the survey included a lack of affordable health insurance (88% importance, 41% satisfaction), medical and dental treatment (90% importance, 42% satisfaction), quality day care (86% importance, 49% satisfaction), and community programs to help pregnant women avoid drugs and alcohol (86% importance, 59% satisfaction). Some relative strengths included the availability of a 911 number for reporting accidents and getting immediate help (92% importance,

77% satisfaction), people’s knowledge of the major causes of heart disease (88% importance, 70% satisfaction), and the fact that the schools educate students about the effects of alcohol and drug abuse (90% importance, 66% satisfaction).

Public meetings were held to discuss with Coalition participants and members of the community the issues identified and possible solutions. For example, in response to the lack of affordable health insurance for all people in the community, alternatives identified during the public meetings included purchasing insurance through a broker to get less expensive health insurance, developing a group plan for the medically indigent, and establishing state-funded subsidies for doctors who treat low-income people. In response to the lack of affordable community programs to help pregnant women avoid drugs and alcohol, the alternatives generated included posting signs to advertise available programs and establishing peer counseling programs.

A direct benefit of this application of the Concerns Report Method was the formation of a local health concerns coalition. This group, composed mainly of consumers, was formed to address several identified health issues; its initiatives included a breast cancer awareness campaign and the development of a local detoxification house for alcohol and drug abusers.

The Work Group on Health Promotion and Community Development secured \$10 000 from the Kansas Health Foundation (formerly the Wesley Foundation) of Wichita, Kan, to field-test a microgrant program. The program was intended to fund small self-help projects designed to address selected health issues identified through the Concerns Report Method. The funds were awarded to the United Way of Douglas County, which disbursed funds and administered the program. The Work Group solicited proposals, coordinated proposal reviews, and provided technical support for microgrant applicants and grantees throughout all phases of the program.

The microgrants program awarded grants to informal and formal organizations addressing defined community health concerns compatible with the Foundation’s primary areas of health promotion and disease prevention: cardiovascular disease, cancer, substance abuse, and maternal/infant care. Priority was given to proposed self-help projects, those with significant involvement by community members experiencing the health problem (e.g., an adolescent pregnancy program led by teenaged

mothers), and projects that encouraged collaboration among community members and organizations.

The community health modification of the Concerns Report Method is a process for setting local agendas for health promotion. As a complement to epidemiologic methods, the method can be used to identify community health concerns of relatively disadvantaged and marginalized groups. The microgrants program provided modest resources to help people affected by health concerns to address them. When used in conjunction with the Concerns Report process, the microgrants program provided a means for leveraging small self-help initiatives consistent with the priorities of marginalized

groups. These community health innovations enable consumers to be involved in health planning, contributing to their control over resources that affect their health and well-being. □

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Copies of the survey and microgrant forms can be obtained from Dr Paine-Andrews for the cost of reproduction and postage. Further information about the microgrants program and about the Concerns Report Method are also available from Dr Paine-Andrews.

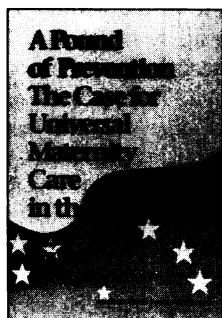
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Reference

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The Case for Universal Maternity Care



A Pound of Prevention: The Case for Universal Maternity Care in the U.S.

Editors: Jonathan B. Kotch, MD, MPH;
Craig H. Blakely, PhD, MPH; Sarah S.
Brown, MSPH; and Frank Y. Wong, PhD
275 pages, softcover, 1992

Approaches—medical supervision, role of neonatal intensive care, benefits of routine health care, health promotion; Maternity and Infant Care 1990: A Decade of Decline—prevalence of the problem, health consequences of inadequate access, barriers to access, issues in providing maternity care, erosion of private insurance; Funding Options for Service Delivery—financing, state insurance plans; Implications for a National Policy—a comprehensive model, standards and quality assurance.

Compared to other advanced nations, the U.S. provides little help and few incentives for protecting the health of child-bearing women and their infants. This text explores current U.S. maternal and child health policies, discusses the prevalence of many problems, calls for radical change, and maps out a blueprint for universal maternity care.

This book is intended for those who formulate and implement maternal and infant health care policy. It will also be of interest to anyone concerned with maternal and infant care.

Contents: Introduction—overview and social consequences of inadequate services; Maternity and Infant Care: Definitions and

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