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**Letter to the Editor**

# Community Assessment for Determining the Health Priority Problems and Community Diagnosis: A Case Study of Qala_Sayed Village, Kazeroun, Fars Province, Iran

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## Dear Editor-in-Chief

Community assessment is the basic and foundation for promoting and improving the health of the community populations. The greater purpose of the assessment process is to improve and promote community health. Community health assessment could provide knowledge about the state of the community health and can create an environment for change**.** To determine how to promote community health requires that community health workers first assess where the community stands (1). Community assessment is performed through many common and uncommon methods**.** The North Carolina model is a very famous model; in a manner, known in America has greatly advanced (1). Interventional programs proposed by the working groups and people are gradually implemented since formulation (2-4). If the community is actively involved in identifying its priority problems, reasons for existence problems can be found. By finding solution with the community and identifying the strong points, attempts can be made to resolve priority problems (5). Determination of the priorities could be an effective and useful method for reforming control programs and health management in different communities (4-7). Finally, while funds are limited, efficient research management requires assigning resources and funds to the problems with higher prevalence and damage that is more serious or harm to the community health. Despite such expectations, less than 10% of the budget of all researches carried out in the world is related to the diseases and problems that cause 90% of all disease burdens (7). The aim of this study was to acquire a proper understanding of these problems and to determine the priorities of Qala-Sayed village.

This study was conducted in Qala-Sayed village, Kazeroun, Fars in 2013. The method used in the study are based on MPH (Master of Public Health) internship model school of public health of Tehran University of Medical Sciences since 1990 and North Carolina model and Hanlon form method in using triangulation method for problem prioritizing and (6). In this model, the process of community assessment is performed in 8 steps as follows:

**Step 1:** Establishment a Community Assessment Team

**Step 2:** Collection of Primary and Secondary Data

**Step 3:** Analyze the Data

**Step 4:** Combined the Data
**Step 5:** Report to the Community
**Step 6:** Select the Health Priorities
**Step 7:** Create the Community Assessment Document
**Step 8:** Develop the Action Plan.

The total population of the village is 2514. There are 649 households in the village with a male population of about 1263 and female population of 1251. The population is rural with majority young people then 25% of the total population is aged below 11years.

The village has one Health House with three qualified Behvarz (community health worker). This village has had water, electricity, telephone, and gas utilities from many years. The village has four schools, five mosques, a nursery school, four stores that sell meat and chicken, and 21 grocery stores. There is also a telecommunication mast and a branch of Post Bank for financial services.

In order to prioritize the problems, a meeting was held with the member of the assessment team and stakeholders and the priority problems were identified using the Hanlon method. General health insufficiency knowledge was identified as the first priority problem followed by diabetes, oral health, addiction, hypertension, etc.

Community diagnosis was implemented to determine the level of knowledge, attitudes, and the practice of residents about diabetes and its related factors. A total of 172 respondents were included. Overall, the knowledge score of the respondents was 60%. There was a significant association between the knowledge of diabetes and training on diabetes [(*P* value=0.002) - Pearson Chi Square] although no such association existed between knowledge and level of formal education.

When the participants were asked whether they received any training on diabetes, only 17.4% gave a positive answer with 90% of them being females. At the same time, a statistically significant association was detected between the level of knowledge and nutritional habits [(*P* value=0.003) – Kruskal Wallis Test].

We conclude that most problems are cultural, social, and not related to health. Although the level of knowledge about diabetes was considerably high among the respondents, there remains task of changing people is feeding habits in village. A lot can be achieved through non-academic trainings designed to improve the people's knowledge about diabetes regardless of their education. Therefore, we recommend a plan of action for training provision for general community on diabetes.

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