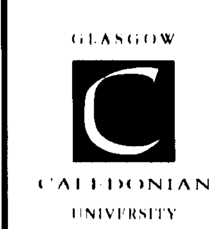

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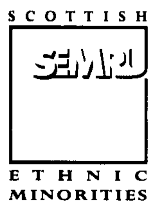
Scottish Ethnic Minorities Research Unit Research Paper: Number 7
Series 2
ISSN 0957 9028

October 1997



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Kay Hampton
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1997

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Abstract

The project was initiated to address the health information, access and utilisation barriers that local Asian and Chinese women frequently encounter due to language, cultural and religious differences. Acknowledging the minimal impact of generic health messages on these women, The Health Education Board for Scotland (HEBS) and Greater Glasgow Health Board (GGHB), Health Promotion Department embarked upon a two year project which proved to be a unique learning experience, not only for the target communities but also for the project planners and evaluators as the chosen methodological approach allowed the latter first hand insight into the processes involved in programme implementation and the social and environmental context in which they took place. The initiative, based on a *'community health education'* approach, initially identified unmet needs and devised a programme which involved the recruitment and training of *'lay'* Asian and Chinese women from the local community to take specific health education messages, using appropriate languages back to the relevant communities. A dynamic, flexible yet organised approach using a range of techniques including, both participant and non-participant observation, focus group discussions and semi-structured interviews were used at critical stages to monitor, develop and evaluate the process and outcome of the programme. The project succeeded not only in establishing a communication process with a marginalised sector of the community, but also opened up an avenue for using similar methodologies to develop initiatives with other *'difficult to reach groups'* within Scotland.

ACKNOWLEDGEMENTS

The evaluation was commissioned by The Health Education Board for Scotland as part of a collaborative initiative with Greater Glasgow Health Board, Health Promotion Department. The Author wishes to express sincere thanks to the following organisations and individuals:

THE HEALTH EDUCATION BOARD FOR SCOTLAND

Lindsay MacHardy...Programme Manager
Sara Maloney...Education and Training Manager
Jenny Secker...Development and Evaluation Officer *(Until Mid 1996)*

GREATER GLASGOW HEALTH BOARD, HEALTH PROMOTION DEPARTMENT

Fiona Toal...Senior Health Promotion Officer (Project Leader and Trainer)
Margaret Robertson...Project Development Worker and Trainer

SEMRU

Mike Dalton...Director *(Until June 1996)*
Jackie Bain...Research Assistant *(Until May 1997)*

THE COMMUNITY HEALTH WORKERS

Rucksana Mahmood
Taiba Qureshi
Nuzhat Mirza
Sneh Lata Midha
Mussarrat Parvaiz
Farkhanda Afzal
Catherine Chau
Julita Pang
Naveeda Iqbal *(Until Mid 1996)*
Neelam Kapoor *(Until Mid 1996)*
Shamshad Chaudhry *(Until Mid 1996)*

Kay Hampton : October 1997

A NOTE ON TERMINOLOGY

For the purpose of this study:

The terms 'minority ethnic', 'minority groups' and 'black and ethnic minorities' are used to refer to 'people of colour' mainly of African/Caribbean, Chinese and Asian descent and those sharing certain common cultural or racial experiences.

The term 'Asian' is used to refer to people mainly of Indian, Pakistani and Bangladeshi Origin.

The term 'Chinese' is used refer to people who originated from China, Hong Kong and the New Territories.

The terms 'trainees' and 'community health workers' (CHWs)' are used to refer to the Asian and Chinese women who were recruited and trained to pass on health education messages to the target group

The terms 'sessions' and 'talks' are used to describe the community work carried out by the CHWs.

The title *'Fook Hong/Sehat'* is derived from terms used by the Chinese (Fook Hong) and Asians (Sehat) to refer to a state of wellbeing.

HEBS: Health Education Board for Scotland

GGHB: Greater Glasgow Health Board

Introduction

Effective dissemination of relevant health information is essential to the promotion of public health, yet to be effective, health promotion efforts must recognise the multi-dimensional nature of communities (Kreps, 1996). It has been identified that varying groups within communities will have differing needs and many researchers agree that these needs should form part of a nationally co-ordinated health education strategy (Bhopal and Donaldson, 1988; Bhopal, 1991; Nottingham Community NHS Trust, 1995).

Culture, ethnicity and gender in particular, are seen as fundamental factors that influence health care access and delivery. There is ample evidence to suggest that certain minority groups, especially women and members of ethnic groups, face numerous barriers in health care particularly in terms of information, access and utilization (AbouZahr et al, 1996; Krebs, 1996). Research has shown that local minority ethnic communities are more likely to encounter barriers relating to the awareness of services, language, culture and religion which need to be addressed within the framework of health promotion (Chaudhry et al, 1993; Sugirtharjah, 1994; Grimes, 1995). At present, although these communities are usually exposed to a wide range of generic health messages some health researchers believe that the effect of these messages is likely to be minimal unless reinforced by more specific ones that are personally 'relevant' to them (Nickens, 1990; Webb-Johnson, 1993).

With relevant health information, users can demystify many of the complexities and ambiguities of illness and improve the quality of their health care decisions. Indeed, Krebs (1996) firmly believes that relevant health information can enable users to grasp a better understanding of their health system, gain insight into the behaviour of health professionals (understand rules, regulations and procedures) and assist in establishing co-operative working relationships with health care providers.

In an effort to disseminate relevant health information to specific at-risk groups, health education campaigns often use a wide range of message dissemination strategies and communication channels including for example; support groups, lectures, workshops, self-help approaches, schools, primary care-based educational programmes and printed materials. These strategies are meant to educate, motivate and empower risk reduction behaviour and are usually generic in nature.

Considering the minimal impact of generic strategies on certain groups, one tends to agree with Nickens (1990) that in order **"...to reach minority populations effectively with prevention information requires messages and programs that are tailored for and targeted to reach a specific audience..."**. Nickens concludes that it is essential for health promoters to especially consider socio-economic factors, cultural variation, country of origin and language when working with minority communities (p138). Reviewing the quality and appropriateness of health education material, Webb-Johnson (1993) adds that there has been little research conducted on the effectiveness of the various media of health information and on the monitoring and evaluation of materials that are produced.

Such limitations to health promotion and adequate service provision have been compounded further by a legacy of misconception and misunderstanding of the health needs of minority ethnic communities which are often too narrowly defined yet involve a degree of complexity, particularly in relation to women's health (Bhopal and White, 1993; Chaudhry et al, 1993). Cultural barriers especially, are not always apparent as some are hidden and may not be recognised in initial interactions.

In this respect, the notion of community involvement and empowerment, allowing health educators to assist individuals in developing confidence, skills and knowledge in making decisions about their own health is fully supported by many (Bhopal and White, 1993; Chaudhry et al, 1993). It has been shown that the use of community health workers and ethnic staff plays an important role in the successful delivery of information (Chaudhry et al, 1993). Bloch (1992), for instance, concluded that face to face information given in the users' own language was more effective than information provided in a written format or over the telephone, and that translated material is not necessarily effective. Researchers agree that this form of participative health promotion should be at grassroots level, involving voluntary and community groups, a useful network which health promoters should key into (Bhopal and White, 1993).

This type of community participation has already been adopted by a number of health service providers with numerous initiatives being developed, mainly based in England, with a slower response from Scotland (Bhopal and Donaldson, 1988).

Against this background HEBS and the GGHB Health Promotion Department recently engaged in a collaborative project *(Fook Hong/ Sehat)* which aimed mainly at reaching and informing women from Asian and Chinese communities in

Glasgow about certain critical health issues with a view to enabling them to make the best possible use of the related preventative services. The underlying focus of this initiative was to provide culturally sensitive information about the main cancer screening programmes for women (breast and cervical) and also to provide information on non-insulin dependent diabetes.

The initiative, primarily based on a *'community health education'* approach, recruited and trained *'lay'* Asian and Chinese women from the community to take specific health education messages, using appropriate languages back to the relevant communities. This paper (based on the commissioned evaluation report prepared for HEBS) discusses the background to the project, the processes involved during the training, the implementation of the programme (community work) and the outcomes (community impact and resource development). The evaluation spanned a period of two years covering the project from the initial planning stages to its conclusion early this year. Key aspects of the project and outcomes are highlighted.

Background to the Project

In terms of promoting health messages to ethnic women, especially those relating to breast and cervical screening, the holistic, person-centred community participation approach has proved to be highly successful in Leeds and Southall (Lai Fong, 1993; Thomas, 1995). The key focus of this approach centers around personal communication, empowerment and the development of a 'critical' awareness. It has been shown to be an effective means of transmitting health education messages to communities where traditional western ones are often difficult to set up (Thomas, 1995). The Glasgow project, the first of its kind in Scotland, was inspired by a project undertaken in Leeds (Lai Fong, 1993) . The strategy used in Leeds was modified and tailored to suit the immediate circumstances of the Asian and Chinese communities in Glasgow.

Initially, whilst little was known about the specific health needs of the local ethnic groups and especially about ethnic women within Glasgow, the problems regarding the lack of relevant health information and poor communication were well documented (Liao, 1994; Avan, 1994). Avan in particular, noted that the usual methods utilised to disseminate information to local black and ethnic minority communities were inadequate and highlighted specific areas of womens health that required addressing in a **"...culturally and religiously appropriate manner..."**. These included for example, matters relating to contraception,

menopause, menstruation and puberty, cervical and breast cancer. Avan regarded relevant health information as the key to empowering people and emphasised that it needed to be appropriately communicated (1994 pp 17-18).

Such evidence confirmed the need for appropriate dialogue between service providers, health educators and members of the community. *Fook Hong/Sehat* aimed at developing a strategy that would encourage such dialogue. The parameters of the project ie: choice of ethnic groups, target areas and subject matter were based on an initial review of the current health circumstances of ethnic minorities in Glasgow.

Given that Glasgow's Ethnic minority population are significantly clustered in certain inner city areas; Woodlands and Garnethill on the north side of the River Clyde and Pollokshields and Govan on the south side of the city (Dalton and Hampton, 1994), the work was mainly concentrated in these areas. Limited resources meant that the project team had to select the most vulnerable groups. Again, based on existing trends, it was felt that women from the Chinese and Asian (Indian and Pakistani) communities were especially disadvantaged in terms of language, communication and access to information and as such that it would be most appropriate to confine the programme to these groups (Health Promotion Department, 1994).

Regarding the selected health topics, the project planning team saw the need to clarify beliefs about breast and cervical cancer (Health Promotion Department, 1994) as previous research indicated lower uptake rates of screening services (both cancer and cervical) for Asian women, (French et al, 1982; Hoare et al, 1992). Evidence in this regard, suggested a link between low uptake rates and limited knowledge, understanding and fear surrounding cancer related illnesses (Hoare et al, 1992; Gutteridge and Callaghan, 1993; Lai Fong, 1994). Moreover, studies assessing screening uptake in Britain showed that rates had improved, notably, after intervention (McAvoy and Raza, 1991; Hoare et al, 1992; Lai Fong, 1994). The project team were thus convinced that an initiative aimed at raising awareness of cancer related illnesses would enhance levels of understanding and subsequently have a positive impact on uptake rates.

Similarly, researchers noted that despite being vulnerable to non-insulin diabetes, knowledge and understanding of the illness was significantly low among ethnic minorities (Mather and Keen, 1985; McKeigue et al, 1991). This prompted the project team to include aspects relating to non-insulin diabetes and healthy eating within their programme.

The project was jointly funded and resourced by the Health Promotion Department (GGHB) and the Health education Board for Scotland (HEBS) and was managed and implemented by a Senior Health Promotion officer (GGHB Health Promotion Department). Key phases involved in the organisation and planning of the initial stages of the project are reflected in **Fig.1 (Appendix 1)** .In essence, **Fig. 1** and indeed, **Figs. 2-6 (Appendix 1)** reflect the progression of key events involved both in the project development and as well as the evaluation. The figures provide a useful guide and easy reference to the discussions that surround the various events highlighted throughout the report.

The Evaluation

The success of an evaluation exercise depends on a number of issues for example, choice of evaluator/s (external or internal), background of evaluator/s (skills, experience, gender, ethnicity) and most important, the methodological strategies and techniques used during evaluations.

In this case, the advantage of recruiting an external team of skilled researchers ensured that the evaluation was conducted with a degree of 'objective neutrality' given their lack of personal involvement in the specific service being evaluated. Moreover, it was an added advantage to have a female researcher of ethnic background on the team as she was able to assess events with insight and sensitivity given her first hand experience, knowledge and understanding of the communities involved.

Yet a potential disadvantage with choosing an external evaluator is that in some cases, health professionals might view external evaluators as non-health specialists who are unaware of many of the issues in its practice (Downie et al, 1991). This could result in poor working relationships, if not initially checked. With the current work, the evaluators found it especially useful to establish an open and trusting working partnership with the project leader, trainers and Community Health Workers (CHWs) from the initial stages of the project which ensured that the role of the evaluator was fully understood and accepted by all.

While evaluations of social programmes flourished during the 70s when programme evaluators were challenged to make evaluative research the primary basis for rational and verifiable programme decision making (evidence based approaches), contemporary researchers argue that programme/project

evaluations ought to go beyond outcomes to include elements that also seek to gain insight into the processes involved in programme implementation and the social and environmental context in which they take place (for example, Feurstein 1988, Macdonald et al, 1996).

It is now widely accepted by many that programme evaluations ought to provide project managers an opportunity to plan and develop both human and material resources on the basis of information gained throughout the evaluation process (rather than at the end of the process) so that progress, effectiveness and efficiency can be systematically monitored and immediately addressed.

The current evaluation adopted an approach which took into account many of the principles highlighted by Macdonald, et al (1996) and Fuerstein (1988) and indeed, followed the basic principles of Illuminative and Responsive evaluation techniques (Reason 1994a, 1994b, Reason and Rowan 1981). While these theoretical models share a number of common ideologies, the essential ones that underpinned the evaluation were guided by the core collaborative and participatory principles outlined by Patton (1990 pp.124-125).

More specifically, regarding the methodological approach taken, the strategies used were tailored to suit the real contexts of the project phases and the abilities and skills levels of the participants involved. The evaluators, being part of the process from the initial stages were able to observe, assess, record and feedback events as they occurred. A dynamic, flexible yet reliable approach using both quantitative and qualitative methods was adopted to compliment the nature of the project. In essence, a multiple method approach (triangulation) was adopted in terms of data sources and techniques used to collect and record data. methods of data collection included for example, participant and non-participant observation, focus group discussions, semi-structured interviews and networking sheets. The key processes involved during the evaluation are reflected in **Fig. 2 (Appendix 1)**

1 Aim and Objectives of the Evaluation

The overall aim of the evaluation was to ascertain the extent to which the project achieved its objectives and to assess whether the model/strategy used is appropriate for working with other marginalised groups within Scotland. More specifically, the primary objectives of the evaluation may be outlined as follows:

- To assess the acceptability, relevance and effectiveness of the training provided to the community health workers.
- To monitor the implementation of the project.
- To ascertain what impact the project has on knowledge and attitudes relating to cervical and breast cancer and diabetes amongst Asian and Chinese women in Glasgow.
- To collate relevant information relating to other health needs of Asian and Chinese women.
- To inform both the development of the project itself, and future work of this kind, by assessing the appropriateness of the process involved in developing and running the project.

In order to achieve these objectives, it was envisaged that the evaluation exercise would encompass three areas of assessment which would subsequently involve three inter-related and inter-dependent phases viz: training evaluation, community impact evaluation and process evaluation. The latter phase was continuous and involved the monitoring of the planning, implementation, development and progress of the project. This was achieved by conducting group discussions and interviews with the project team and community health workers at strategic intervals and key developments, amendments and modifications in terms of the project were identified, recorded and built into the project **(Fig. 2 : Appendix 1).**

2 The Training Evaluation

Given that the primary purpose of *Fook Hong/Sehat* was face to face communication in relevant languages, 11 *lay* women were recruited, mainly on the basis of their fluency in various ethnic languages (Urdu, Punjabi, Hindi, Cantonese, Hakka and Mandarin) to undergo training as community health workers.

These women, who will be referred to as Community Health Workers CHWs hereafter, received a core training which covered relevant information relating essentially to breast and cervical cancer and screening service and aspects of healthy eating. The training programme was designed by health promotion

professionals with input from the CHWs, to ensure appropriateness, cultural sensitivity and relevance. The CHWs received 20 (two hours) training sessions (conducted over 20 weeks) and additional refresher training sessions at regular intervals to increase their effectiveness as community health education workers.

The training took the form of workshops, role play and small group discussions during which essential aspects relating to the three illnesses, communication skills and procedures involved in organising community work, were covered. The training also included visits to local well-women clinics and breast screening units, to allow the CHWs the opportunity to evaluate the local services in terms of their own communities' needs.

In order to assess the impact and the extent to which the training programme had achieved its aims, assessments were conducted prior, during and after the core training. In addition, an assessment was also conducted during the fieldwork to establish the suitability of the training in terms of practical application. The trainer's perceptions of the training programme and it's relevance to the proposed work were also assessed. By the end of the core training period both the CHWs and trainers were confident that the CHWs were appropriately equipped to conduct the proposed community health work. (details pertaining to the methods used, process involved during this phase of the evaluation and the key outcomes are discussed fully elsewhere (SEMRU 1995, SEMRU 1997),

3 Community Impact Evaluation

Prior to commencing work in the community, the CHWs were given guidelines on the practical aspects of community health work. This area of training covered topics relating to: Finding an Identity, Networking in the Community, Communication Skills, Presentation Skills, Group Work Skills and Record Keeping.These particular training sessions contributed greatly to the organised and systematic manner in which the community work was conducted.

A close examination of the pilot work indicated that the CHWs had not simply regurgitated the guide notes instead in many cases, they had attempted to include individual perspectives thus presenting the information in ways that proved to be more suitable and appropriate to the situation on hand. This is a positive indication of how well the material was understood by the CHWs and also of their ability to apply them practically.

As with the training evaluation, the community evaluation also ran parallel to the programme implementation with assessments being conducted prior, during and post programme implementation. Regarding data collection, in addition to semi structured interview schedules and recordings from group discussions, specific *'networking sheets'* were designed to assist the CHWs record contacts and appointments, plan sessions (in terms of time, topic, methods to be used, preparation time) and conduct self evaluation.

The sheet guided the CHWs to operate in a manner, similar to that of a professional health promotion worker. This aspect not only added to the credibility and acceptance of the CHWs within the community but also contributed to the smooth management and monitoring of the programme. The networking sheets were regularly assessed by the evaluators and provided an essential source of information especially in terms of issues raised, difficulties encountered and identification of other health needs within the community.

The Pre-test

The pre-test interviews were conducted by the CHWs prior to commencing the core programme. Ensuring an even representation of respondents in terms of age, ethnicity and language, the CHWs interviewed 40 women during the pre-test survey. Regarding the three illnesses, the pre-test survey showed that non-insulin diabetes tended to be more commonly experienced by respondents (32..5%) than either breast or cervical cancer. As a Result, respondents were more aware about matters relating to diabetes (albeit not totally accurate) than about breast and cervical cancer. Indeed, the majority of the respondents indicated that they had not received any substantial health promotion information on either cervical (85%) or breast (75%) cancer, previously. Nonetheless some had attended screening services without fully understanding the importance of screening:

"... most women had gone for breast screening and cervical smear test but no one talked to them about this...they received a letter of appointment and just went..."

"...how do we examine our breasts?... no one explained how and what we should be looking for in self examination?..."

"... I have been for some (smears)...do I still have to go for a smear test after menopause?..."

Importantly, the pre-test data, despite being relatively small in scale and somewhat focused, succeeded in providing useful indicators with respect to the knowledge base of the target groups. This information was valuable for the development of the community work that followed.

The Post-test

During the course of the programme (18 months), the CHWs had succeeded in reaching a substantial number of Asian and Chinese women through various points of contact within the local community.

The flexible nature of the project allowed the community work to extend well beyond the initial expectations and as a result *Fook Hong/Sehat* which was initially confined to *'known'* community centres/projects and individual private homes, soon expanded to cover a wide range of organisations and events within the local area. The key points of contact where most participants were reached included for example, Community Centres, Health Information Points, a Chinese Health Gala, Diabetes Road Shows and GP surgeries **(Table 1)**.

Table 1 Estimated number of people reached at Contact Points

	Contact Points	Number of People
Community Centres	41	1500-2000
Information Points	2	170+
GP Surgeries	4	40-50
Individual Homes	200	200+
Diabetes Roadshows	4	85+
Chinese Gala	1	100+

Art Work by ProMac Graphics 1997

Table 1 shows that more than 40 community centres, 2 information points, 4 GP practices, 3 diabetes road shows and a Chinese Health Gala were covered. Although a number (approximately 200) of individual (one to one) sessions were conducted, the majority of the community work was done within groups.

Whilst the number of participants within the groups varied with the largest being approximately 140, an average group size was generally around 9. In terms of the number of sessions conducted within a contact point, while an average of 6

sessions was estimated it was evident that in some cases the CHWs conducted as many as 18, depending on the interest shown.

The community centres proved to be the most successful contact point at which the CHWs reached and worked with approximately 1500-2000 women during the 18 month period **(Table 1)**. As could be expected, the actual number of participants attending the health sessions varied in terms of the group' commitments to other scheduled activities within the centre yet there is evidence to show that participants generally displayed sustained interest in the community health sessions. Almost two thirds of those interviewed during the post-test survey had attended at least three sessions and a substantial number (14.3%) more than five.

Similarly, the CHWs recorded approximately 170 individuals at the two Health Information Points (Pollokshields and Garnethill). The extent of the work at these points was estimated to be much greater as least 25% of those who registered indicated that they had shared the resources they borrowed with other individuals or groups, thus implying a wider dissemination range. The CHWs, participants and project leader viewed this as a highly successful event particularly in terms of relevant health information dissemination.

The Chinese Health Gala, a three day event run by the GGHB Health Promotion Department and the local Chinese community was considered the more successful contact point in terms of reaching members of the Chinese community. During this event, although around 100 individuals were accounted for at the Fook Hong/Sehat stalls, the actual impact of the event needs to be appreciated in terms of the high level of awareness raising and the dissemination of accessible health information on cancer and diabetes, to the Chinese community.

Likewise, the true value of the initiative at GP practices should not be measured simply in terms of the 40+ participants accounted for during this project, instead, the ultimate benefit lies in the project's successful acceptance within a primary health care setting. Indeed, one of the most remarkable achievements of this project is that it has shown that a community based initiative, when carefully planned and managed can be successfully integrated within a primary care setting.

In the case of the of the diabetes road shows, *Fook Hong/Sehat's* contribution proved to be a successful example of collaborative work between both statutory and non-statutory organisations. The road show which involved the Acute Trusts,

Community and Mental Health Services NHS Trust, Voluntary Sector Organisations, British Diabetic Association and GGHB Health Promotion Department (Fook Hong/Sehat) acted jointly as a catalyst to review their health activity among ethnic communities. Indeed, the event provided an ideal opportunity to enhance the dissemination of relevant health information to members of the ethnic community.

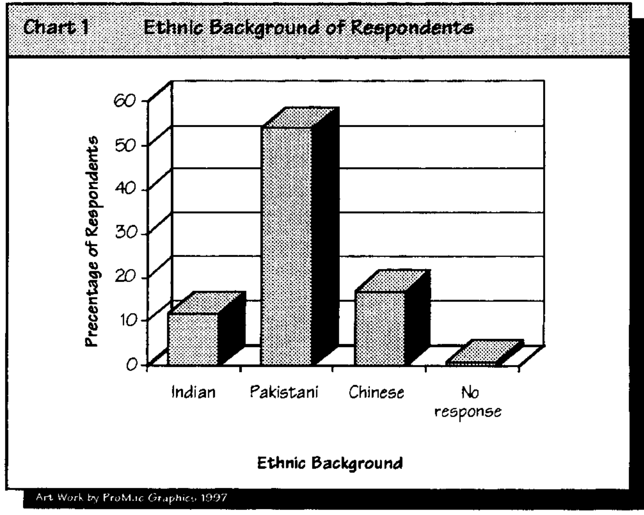
Work within the community usually took the form of a series of presentations covering all three illnesses, breast and cervical cancer and diabetes. The CHWs initially approached the co-ordinator or manager of the centre (project), arranged appointments and invited regular users of the centre to participate in the programme. This process had to be carefully negotiated as the managers of certain centres were at times reluctant or unable to allow the CHWs time to conduct their work as their regular scheduled activities took precedence. Yet, despite these practical difficulties, the CHWs were extremely successful in reaching and working with more than 2000 women from the target communities.

Key Findings

Within the context of the overall objectives of the project, one of the primary aims of the programme evaluation was to establish the extent to which the chosen health promotion strategy succeeded in reaching and informing Asian and Chinese women about the three identified health issues (breast and cervical cancer and non-insulin diabetes) and whether or not the programme had influenced the lifestyles and attitudes of participants. There was ample evidence to show that the project had achieved it's aims:

i) The Respondents

Since culture, language and communication formed the key elements of this project, the evaluators were pleased to note that there was a fair representation of participants in the sample in terms of language and ethnicity. A close examination of the data showed that the ethnic pattern of distribution within the sample, was similar to the overall ethnic distribution in Glasgow. Collectively, the Pakistani (50.5%), Indian (15.6%) and Chinese (12.9%) communities constitute more than three quarters (79.3%) of the total ethnic population in Glasgow (Dalton and Hampton, 1994). Likewise, the majority of the respondents in the sample were of Pakistani origin (64.1%: **Chart 1**).



As could be expected, language and ethnicity patterns were closely related. Punjabi appeared as the most commonly used language amongst the Asian Community and members from both the Pakistani and Indian community indicated that they were more inclined to use Punjabi a first language (**Table 2**). Moreover, **Table 2** shows that a fair proportion of the respondents also used Punjabi in conjunction with either Urdu (17.9%) or Hindi (5.9%).

Table 2 Language of Respondents

	Number	%
Urdu	3	3.6
Hindi	2	2.4
Punjabi	27	32.1
Cantonese	9	10.7
Hakka	4	4.7
Punjabi and Urdu	15	17.9
Punjabi and Hindi	5	5.9
Cantonese and Hakka	4	4.8
Ethnic Tongue and English	15	17.9
Total	84	100.0

Art Work by ProMac Graphics 1997

Interestingly, the above table (**Table 2**) indicates that none of the respondents used English as a first language with only a small number (17.9%) using it as a second language. These findings are especially significant in that they reflect the proportion of people who might have been missed in generic health campaigns which are usually conducted in English. In particular, The Chinese respondents would have been most disadvantaged as cross examination of the data revealed that none of those interviewed used English to communicate.

ii) Impact of Community Work

Almost two thirds of the respondents (61.9%) attended at least three sessions and a substantial number (14.3%) more than five (**Table 3**).

Table 3 Number of Sessions Attended

	Number	%
One	14	16.7
Two	18	21.4
Three	29	34.5
Four	8	9.5
Five	3	3.6
More than five	12	14.3
Total	84	100.0

Art Work by ProMac Graphics 1997

The attendance pattern reflected in **Table 3** indicates that most respondents showed sustained interest in the subject matter and the majority attended more than one session. The positive interest shown by community participants was also noted by the CHWs who commented (as extracted from the CHWs evaluation sheets):

"...the positive aspect of this session was that the ladies were looking forward to our next visit so that we may cover breast screening...they were enthusiastic about the project being set up especially with them in mind..."

"...the positive aspect of this session was the interest the women showed in the subject...the information was of great value..."

"...they were very interested in our talk and asked different questions about diabetes..."

iii) Impact of Sessions on Levels of Awareness/Knowledge

It is apparent from **Table 4** that respondents knew relatively little, about the three illnesses prior to attending the sessions, especially with regard to cervical and breast cancer. Indeed a large number indicated no knowledge whatsoever about cervical (42.4%) and breast cancer (34.3%).

Table 4 Respondents knowledge prior to attending Sessions (Post-Test Sample)

	Cervical		Breast		Diabetes	
	Number	%	Number	%	Number	%
Knew a lot	8	13.6	8	11.9	20	25.6
Knew little	26	44.0	36	53.7	37	48.7
No knowledge at all	25	42.4	23	34.3	19	24.4
Number Attended	59	100.0	57	100.0	76	100.0

Art Work by ProMac Graphics 1997

It was therefore encouraging to note that the majority (**Table 5**: Cervical: (52,5%; Breast 47.7% ; Diabetes 52.6%) had learned at least *'a few new issues'* about the three illnesses.

Table 5 Impact of sessions on respondents knowledge of Breast/Cervical Cancer and Diabetes

	Cervical		Breast		Diabetes	
	Number	%	Number	%	Number	%
Learned a lot	20	33.9	26	38.8	22	28.9
Learned a few new issues	31	52.5	32	47.7	40	52.6
Learned very little	6	10.2	6	8.9	12	15.7
Unsure	2	3.4	3	4.4	4	5.2
Number Attended	59	100.0	67	100.0	76	100.0

Art Work by ProMac Graphics 1997

The majority of those interviewed during the post-test survey (64.3%) indicated that they had enjoyed all the sessions they attended and at least a quarter (24%)

considered the topics on diabetes and healthy eating to be especially useful. Similarly, more than a third (33.9%) who attended the cervical and breast cancer sessions mentioned that they learnt a great deal from them (**Table 5**)

iv) Impact on Lifestyles

The impact of the diabetes sessions on respondents' lifestyles was noted mainly in their attitudes towards food preparation and their eating patterns. More, specifically, at least than 7 in 10 of those who attended the diabetes sessions pointed out that the talks had influenced their lifestyle in a positive manner. In particular, **Table 6** below shows that while more than a third (39.5%) of the respondents felt that the sessions had made a slight impact on their diet, at least a fifth (19.7%) believed that the sessions had influenced on their diet *'very much'*.

Table 6	Influence of Diabetes talks on respondents lifestyle	
	Number	%
Influenced diet very much	15	19.7
Slightly influenced diet	30	39.5
Heightened awareness on healthy eating	8	10.5
Need more information/diet unchanged	10	13.2
No influence	13	17.1
Total	76	100.0

Art Work by ProMac Graphics 1997

This aspect inspired a great deal of discussion during which some respondents explained how that they had changed from *'regular'* food to low fat alternatives whilst others described how they had taken to substituting healthy ingredients in their cooking, eating more fruit and vegetables and changing their shopping habits. Others related how they had altered their meal times, eating more regularly and correctly. The following extracts from discussions provide some insight into the nature of the impact:

"...after the talk, I learned how to eat healthily... I have no meals directly before bedtime, drink semi-skimmed milk instead of full fat...also eat more healthy foods..."(Chinese Respondent)

"...that (diet) was something that I always wanted to change but was unsure as to how to do it without altering my whole diet...it helped me change my eating habit..."(Asian Respondent)

".. I now have regular meals, more fruit and vegetable and even started taking vitamin supplements such as iron..."(Chinese Respondent)

"...now take skin off meat, do not have too much salt or sugar and I exercise more now..." (Chinese Respondent)

"...by changing my cooking and eating habits, I feel much better.."(Asian Respondent)

"...after listening to the talks I think twice before eating anything and I am very careful about buying any wrong things, I am more conscious about good food and bad food..." (Asian Respondent)

Interestingly, although both the Chinese and Asian respondents had indicated certain positive changes in their eating patterns, the Asian respondents were especially keen to find out more about healthy food preparation and requested practical suggestions in this regard. Concerns relating to the preparation of traditional food were noted where it was felt that the essential flavour would be lost if certain types of food was prepared without the usual traditional ingredients.

This aspect was highlighted earlier in the project and as a result the project leader encouraged a group of Asian CHWs to design and write an Asian recipe book based on the use of healthy ingredients. The book, produced by GGHB Health Promotion Department and HEBS (Mahmood, et al 1996) is bilingual (English and Urdu) and is a popular health promotion resource.

Turning specifically to breast and cervical cancer, although the long term impact of the programme on the lifestyles of recipients is difficult to anticipate at this stage, the immediate (medium term) signs were equally positive. For example, the overwhelming majority (89.5%) of those who attended the breast and cervical cancer sessions indicated that, given the additional information, they would be willing to go for breast screening, if invited (**Table 7**)

Table 7 Respondents willingness to attend Breast and Cervical Services

	Number	%
Yes	60	89.5
No	6	9.0
Unsure	1	1.5
Total	67	100.0

Art Work by ProMac Graphics 1997

Reservations (noted during the post-test survey) regarding the latter were related mainly to feelings of embarrassment and anticipated communication difficulties at the service centres:

"*...I would go only if there was a support worker...*" (Chinese Respondents)

"*...I need someone to make an appointment for me and to take me, however I am over 70 years and don't really think I need to go...*"(Asian Respondent)

"*...older people feel very embarrassed about this issue and will only go if there was a problem...*"(Chinese Respondent)

"*...I used to go regularly in Hong Kong, now in Britain I go sometimes...would go more often if there wasn't so much communication barriers, it can become very embarrassing to talk about it through someone else...*"(Chinese Respondent)

Still, the positive comments in this regard outweighed the negative ones and it was evident that a fair number of respondent not only appreciated the importance of attending breast screening but equally understood the importance of doing so:

"*...I think that we should have early screening to detect if there is anything wrong...*"(Asian Respondent)

"*...After the talk I got my smear test done, that was about two weeks ago and I am now waiting for the results, yes I will go again, it's not so bad...*"(Asian Respondent)

"*...if I receive a letter, I will go, I understand why I need to go...*"(Chinese Respondent)

"*...yes I will (go for one) because I now know what happens and why it is so important to go for a smear test...*"(Asian Respondent)

"*...The information I received about breast screening from... was useful and I would be happy to go for screening...*"(Asian Respondent)

"*...I went for breast screening about five years ago and again after the talk, but was told that I was not due for one, I intend going to my own area clinic...*"(Asian Respondent)

The acceptance of the project as a relevant one for the Asian and Chinese communities is ultimately reflected in the respondents' willingness to recommend the sessions to other members of their community. The overwhelming majority (92.9%) of those interviewed believed that the current work would definitely be beneficial to other members of their community and almost all (94%) were willing to recommend similar sessions to others within their community:

"*...this type of work will help Chinese women understand more about health issues, women don't know where to look for information, these talks will help them...*" (Chinese Respondent)

"*...it is the only opportunity for them (the women) to talk about these issues in their own language and they can share their concerns with others freely and comfortable to ask questions...*" (Asian Respondent)

"*...it (the project) gives practical support and is better understood as there are no language barriers...*" (Chinese Respondent)

"*...women in our community need to know about these issues (breast and cervical cancer) and many are reluctant to see the doctor or if they do, they feel uncomfortable to ask about it... a lot of women are house bound and go only to community centres...so it was a good idea to contact them there...*" (Asian Respondent)

"*...many women in our community do not know about these problems and are shy to ask anyone, it would benefit other women especially as the talk is done in their own language...*" (Asian Respondent).

Similarly, regarding the methods used to deliver the health messages, Asian respondents, in particular commended the idea of using appropriate languages:

"*...everything was explained in our own community language which was useful to all of us...*" (Asian Respondent)

"*...it was easy to understand, especially since it was in our own language and delivered by women from our community...we felt more at ease to ask questions...*" (Chinese Respondent)

"*...this was the first time something like this was done in our language and I found it very useful and easy to follow... also it was nice to know that our feelings and opinions were considered in the delivery of the messages...*" (Asian Respondent)

Key Outcomes

Overall, it is fair to conclude that not only had the project succeeded in reaching a substantial number of Asian and Chinese individuals and groups in Glasgow (both within community and primary care settings), but it proved to be equally successful in raising the target populations' awareness of the three illnesses (breast and cervical cancer and diabetes).

Additionally, the programme had provided the local Asian and Chinese communities the opportunity to receive relevant health information in an appropriate manner while providing a forum for discussing important health issues that were previously considered embarrassing or even taboo, by many.

It is often difficult to measure lifestyle change or direct impact of programmes, but the approach taken allowed the evaluators to obtain the true feelings of all those involved (community members, CHWs, professionals). There was evidence to show that generally, participants were keen to alter their current lifestyles in a positive manner. Indeed, there were clear indications that a number of them had already done so.

This evaluation had shown that project outcomes do not consist solely of factors that can be counted or measured, they often involve a range of factors that are usually difficult to measure in quantitative terms yet influence programme success or failure in important ways. These include people's behaviour, abilities, qualities, attitudes, value and motivations and most important, how people relate to one another and to the project (Feuerstein, 1986). Although the evaluation considered both the quantitative and qualitative outcomes of the project, the emphasis was nonetheless on the qualitative aspects as this was considered more relevant, given the nature of the work.

Overall, if one has to judge the outcomes of this project in terms of *'strengths'* and *'weaknesses'*, then one has to conclude that the strengths outweigh any weaknesses that might have been noted. Indeed, valuable outcomes many of which were unforeseen in the early stages have been discussed throughout this paper. Still, certain positive aspects that could be useful for the planning of similar projects in the future need to be highlighted

The evaluators believe that a factor which contributed significantly to the success of this project was the tremendous team spirit that existed throughout the project, it was truly a collaborative initiative. More importantly, the project demonstrated that people, in this case mostly women, of different ages and from various cultural backgrounds can work successfully together by sharing experiences and gaining a better understanding of each other's behaviour and expectations.

In this regard, it is fair to say that the project was a unique learning experience, not only for the target communities but also for the CHWs and the professionals (project team). In particular, the regular group discussion meetings held between CHWs, trainers and the project leader assisted in providing a valuable forum for sharing unique experiences, airing differences and considering new developments.

This pattern of communication which continued throughout the project contributed to the systematic monitoring and smooth management of the community work. Another factor that played an equally important role was the careful yet flexible and sensitive approach undertaken during the planning and implementation of the project. An added advantage was that a core team of highly committed workers remained with the project until its completion, ensuring consistency throughout.

If one is seeking shortcomings, then the issue of resources must be considered more closely. In this case, the staff allocated to manage the project was limited. Whilst the number of CHWs recruited turned out to be adequate, staff resources in terms of project management was limited and as a result the project leader not only had the responsibilities of planning and co-ordinating the overall project work but also had to take responsibility for certain elements of the training.

Despite the project being successfully concluded, similar initiatives in the future need to consider recruiting an additional worker at the managerial level. Careful consideration of resources is crucial given the unexpected and additional areas of work that can emerge with a project such as this one. For example, during the

early stages, the work was confined to specific aspects (training and community work) but later evolved to include tasks related to resource development which ultimately enhanced the community work.

In addition to the key initiatives mentioned throughout, other secondary ones for instance, the provision of additional relevant training for the CHWs and the development of resources including, the Asian Healthy Eating Recipe Book, Asian and Chinese healthy eating Food pack and Cervical Smear Teaching Tool are worthy of mention. The project leader also undertook to organise other related events and activities for the CHWs who became involved in assisting with aspects of racial awareness training, attending seminars on cancer issues and participating in general work relating to breast and cervical screening and diabetes (training course for ethnic minority workers, Health Promotion Foundation (short courses).

Ultimately, one cannot help but focus on the overall value and benefits of the project as these are echoed by all those who were involved, especially members of the community and the CHWs. The message is clear, specific audiences were successfully reached and their needs directly identified. Consequently appropriate information was successfully delivered.

Conclusion

Programme managers and evaluators often review the quality of strategies used in community development programs without paying much attention to the programme participants' perspectives, as in most cases access to participants, especially members of the community, is restricted. This evaluation has successfully managed to obtain the views of all participants (community members, project leader, CHWs and trainers) and in a sense, they were the primary critics of this project.

In concluding, it can be said that not only had *Fook Hong/Sehat* succeeded in building beneficial links with sectors of the local minority ethnic community and developing the skills and confidence of the CHWs, it also opened up an avenue for using similar methodologies to develop initiatives with other marginalised groups in Scotland. It is hoped that the efforts and resources invested in this project in establishing a way forward will be rewarded by the sustained interest and support of statutory service providers.

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Appendix 1

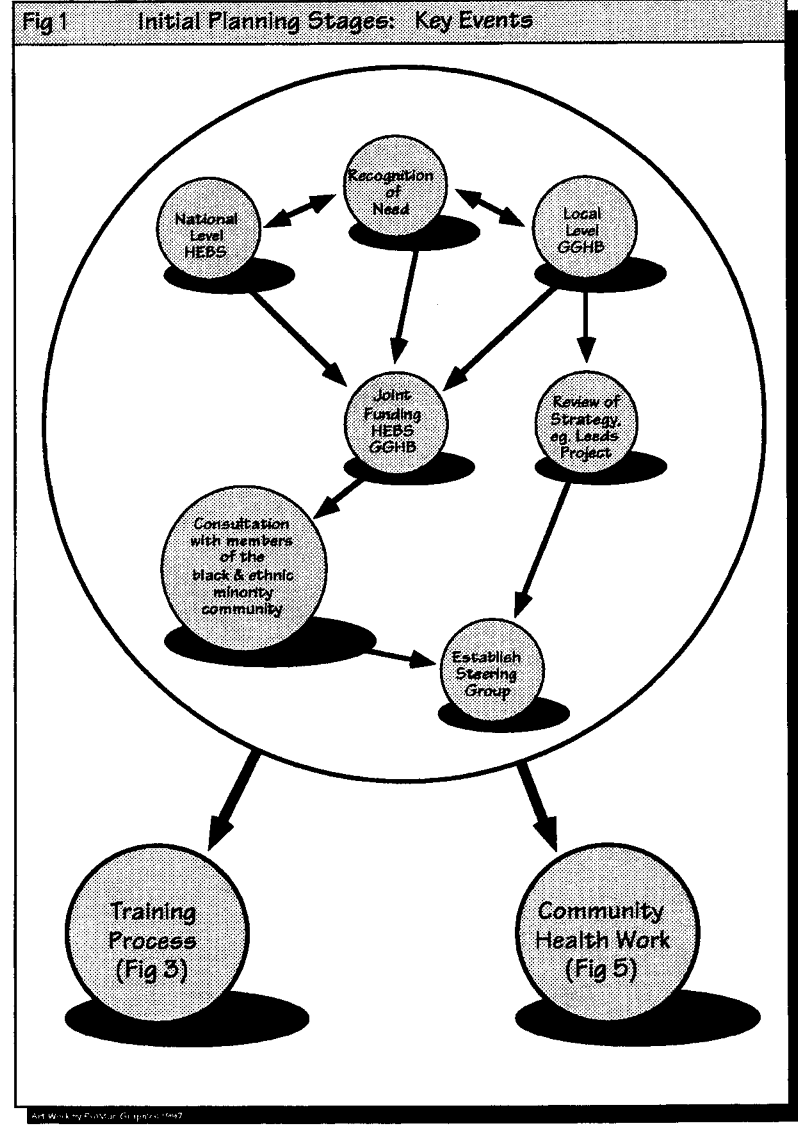

Fig 1 Initial Planning Stages: Key Events

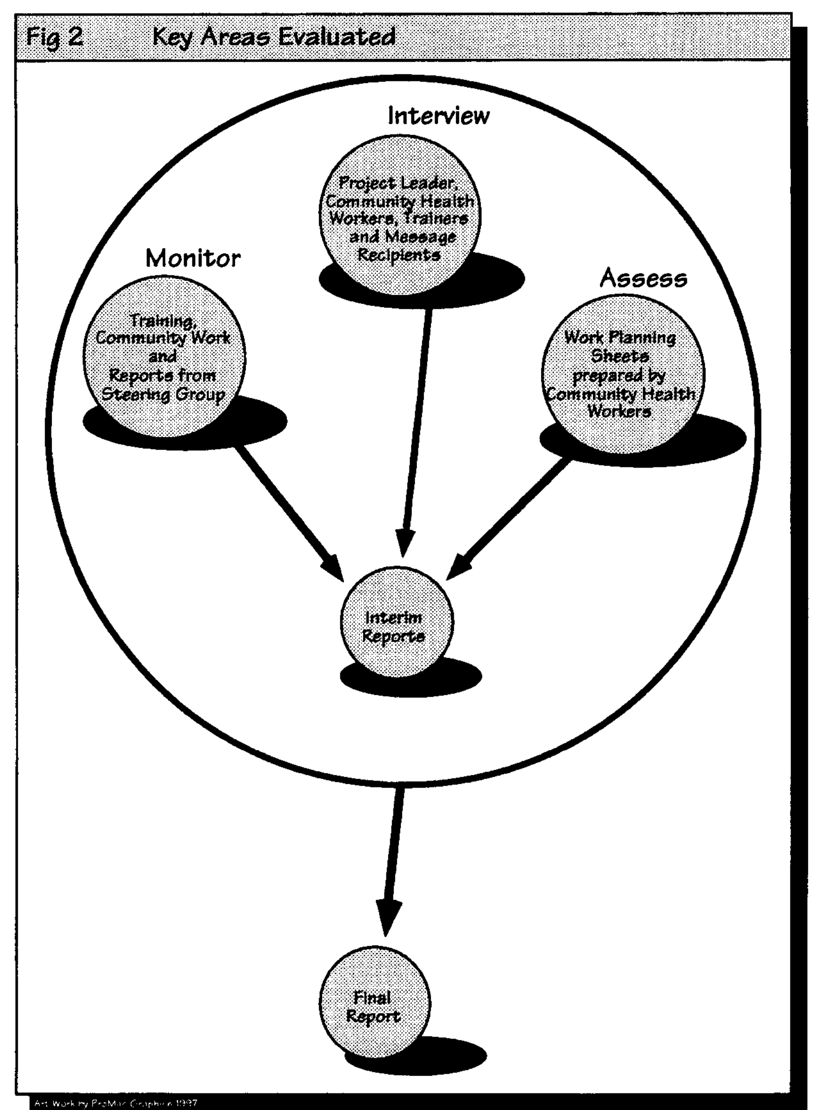
Fig 2 Key Areas Evaluated
Interview
Project Leader, Community Health Workers, Trainers and Message Recipients
Monitor
Training, Community Work and Reports from Steering Group
Assess
Work Planning Sheets prepared by Community Health Workers
Interim Reports
Final Report
Art Work by ProMac Graphics 1997

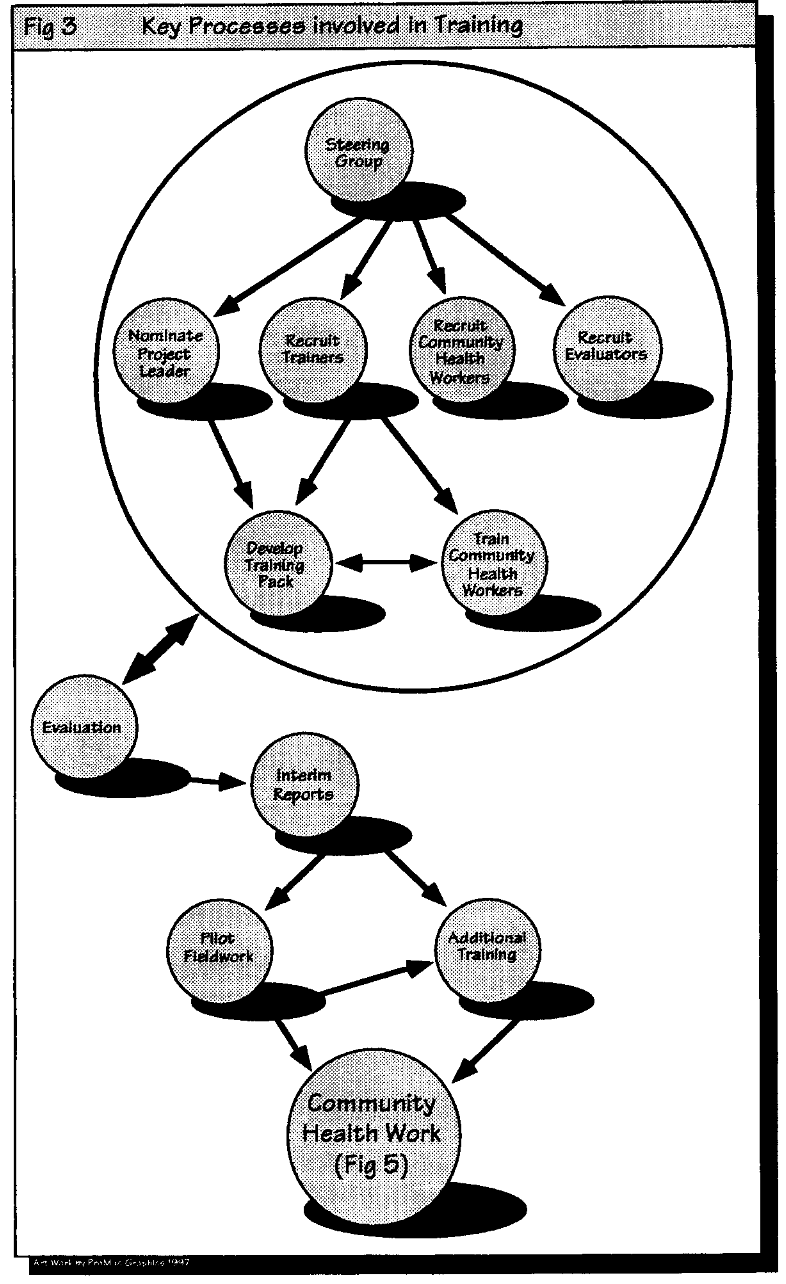
Fig 3 Key Processes involved in Training
Steering Group
Nominate Project Leader
Recruit Trainers
Recruit Community Health Workers
Recruit Evaluators
Develop Training Pack
Train Community Health Workers
Evaluation
Interim Reports
Pilot Fieldwork
Additional Training
Community Health Work (Fig 5)
Art Work by ProMac Graphics 1997

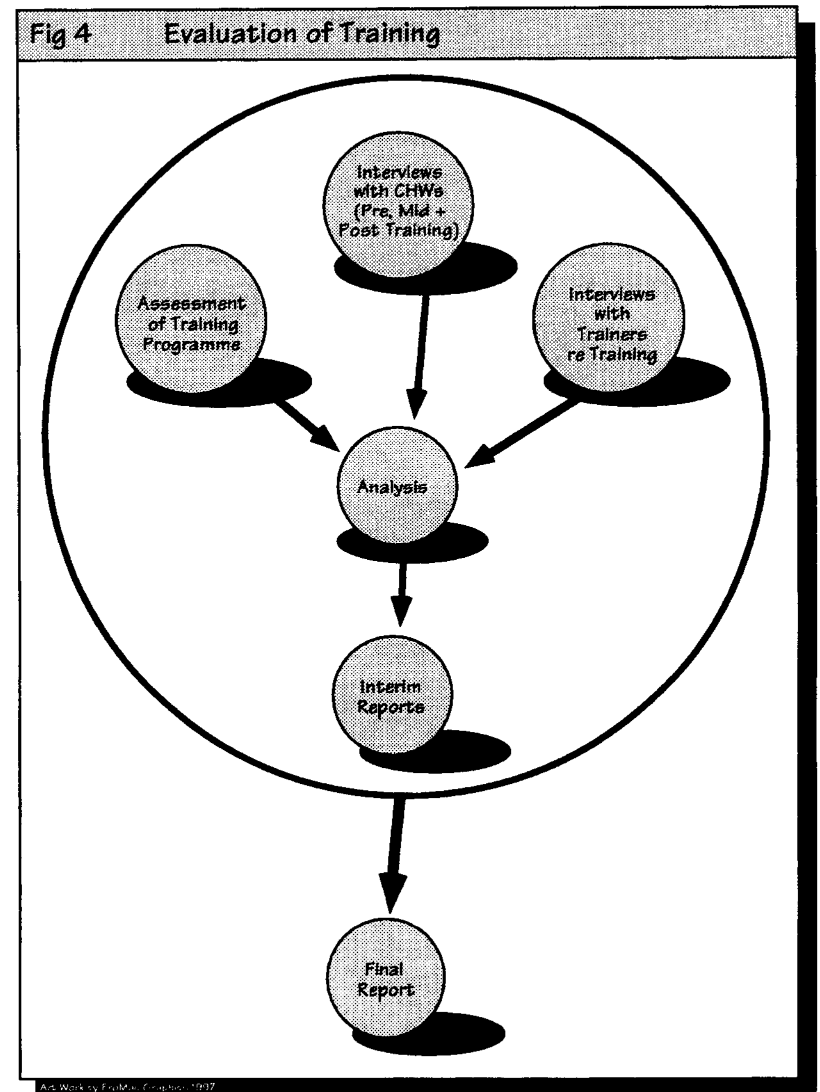
Fig 4 Evaluation of Training
Interviews with CHWs (Pre, Mid + Post Training)
Assessment of Training Programme
Interviews with Trainers re Training
Analysis
Interim Reports
Final Report

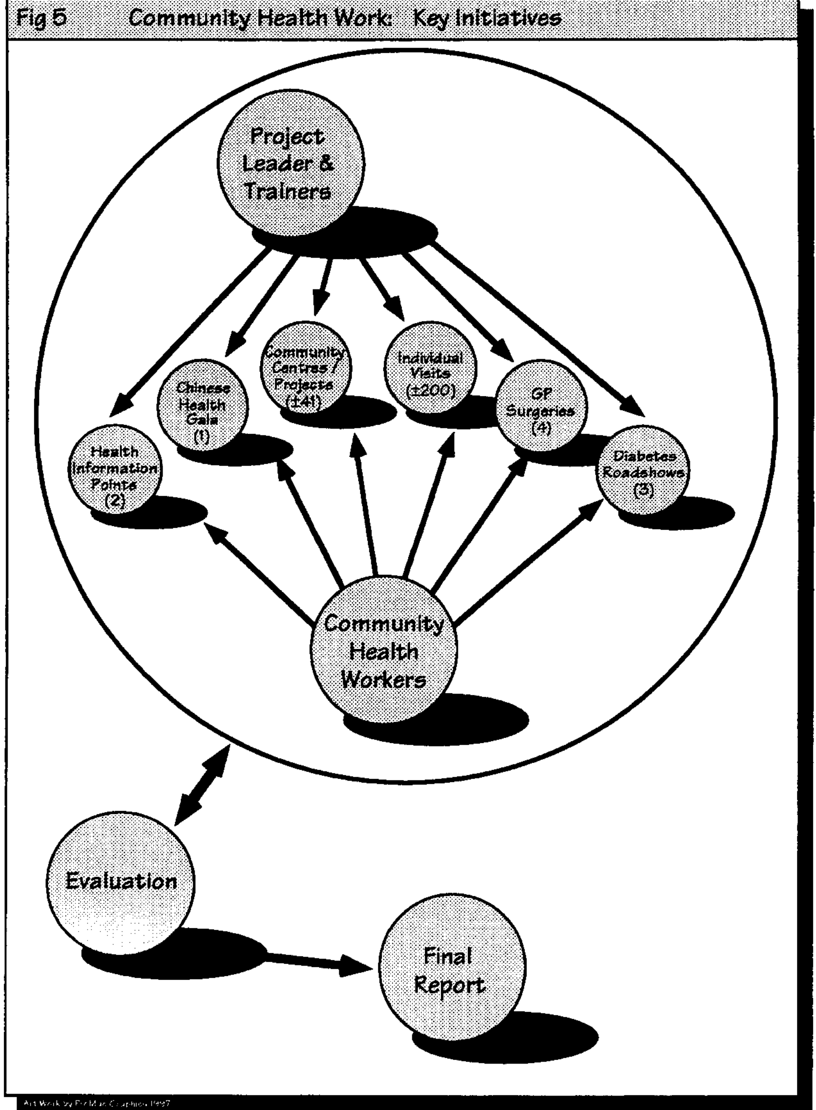
Fig 5 Community Health Work: Key Initiatives
Project Leader & Trainers
Health Information Points (2)
Chinese Health Gala (1)
Community Centres / Projects (±41)
Individual Visits (±200)
GP Surgeries (4)
Diabetes Roadshows (3)
Community Health Workers
Evaluation
Final Report

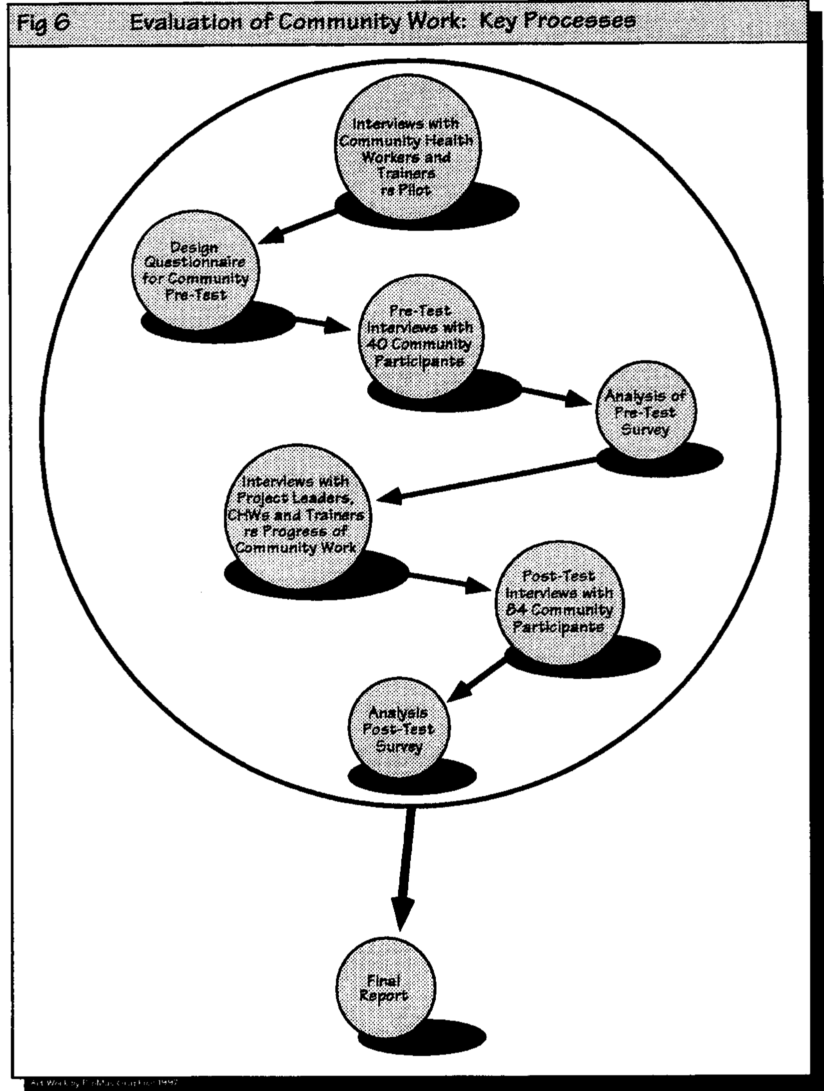

Fig 6 Evaluation of Community Work: Key Processes