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Using Qualitative Methods to Develop and Evaluate a Health Promotion Strategy: Asian and Chinese Women's Health Project In Glasgow

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This paper focuses on a project that utilised qualitative methods to successfully develop and evaluate a health promotion programme within communities that are generally difficult to reach. The project was initiated in response to current debates surrounding access to health services, in Britain. Acknowledging the minimal impact of generic health messages on certain sectors of the community, a team of health promotion officers and researchers 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, observation (both participant and non-participant), 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 qualitative approach adopted not only succeeded in building useful links with difficult to reach communities but provided a useful strategy for working with other marginalised groups within Scotland. The strategy is currently being reviewed as a model for conducting similar programmes of work.

Introduction

I would like to add an additional dimension to the conference theme ("Touch me I'm Sick")...'empower me and I'll decide whether I'm sick and need healing'... as I feel that the knowledge base of people and their particular health needs are often taken for granted by most professionals and service providers. In the UK, in particular, service providers generally accept that everyone in our community is equally informed about health matters and know how to maintain their well-being as the 'best' health services are in place for all to access. In reality, our social programmes and health services are mostly generic in nature, based on generalisations about the populations health needs and are aimed primarily at the so called average 'Brit' or 'Scot'.

While I have to concede that certain factors such as poverty and social class are sometimes considered when planning service delivery, issues of access are usually ignored. Recent research in Britain has tended to highlight the marginalisation suffered by certain communities in terms of health service provision and as a result service providers and professionals have been forced to review traditional modes of practise. Unsurprisingly,

nobody appears to know where to start making changes... some statutory agencies are reluctant to change while others claim to have limited resources and the rest don't quite know what to do. In this current situation of confusion, a number of community based projects have arisen in an attempt to address the health issues that the statutory organisations are shy to tackle. The initiative I am about to discuss is one such project, which originally aimed at establishing a communication process but evolved into a successful health education programme which is currently being considered as a model for working with other marginalised groups and individuals, throughout Scotland.

Context: The Many Faces of Glasgow

People view Scotland in many and varied ways... some see the Scots as the poor relation of the English, living in a country that is constantly cold grey and bleak while others have postcard images of soft rolling hills and quaint country villages. Indeed, although proud of it's traditional culture, Scotland has various faces, some pleasant others not. Our work was conducted in Glasgow, located in the west of the country, on the river Clyde. Glasgow has fought an external image of poverty, slum housing, violence and drunkenness and in recent years is promoting alternate images of a proud working class society and a European cultural centre.

The population of Glasgow is small, just over 676,300 (Dalton and Hampton, 1994). At best the population can be described as multi-racial, multi-ethnic and multi-cultural. After the Second World War migrant workers from the empire and commonwealth were attracted to settle in the city. They came mainly from the Indian subcontinent, and to a lesser degree, Hong Kong. In Scotland, these communities constitute just under 2% of the population (62, 636) and are generally referred to as ethnic minorities. The communities are concentrated in the four main cities of Scotland and approximately a third (21 571) live in the inner city areas of Glasgow. The ethnic population is generally youthful but the majority of first and second generation members tend to be socially disadvantaged and the women in particular, suffer chronic isolation and alienation due to language, cultural and religious differences. A substantial number are unable to speak, read or understand English, depending heavily on interpreters. Our project attempted to reach and inform women from these communities about certain critical health issues with a view to enabling them to make the best possible use of the related preventative services.

Project Background

I was initially approached by a group of health professionals who expressed their concern relating to the low uptake of (breast and cervical) cancer screening services by Asian and Chinese women. These professionals, all White women, described how they had tried and failed to attract the attention of Asian and Chinese women or to influence their health behaviour in any positive manner. They were seeking to establish an alternate way of communicating with women from these communities. They believed that I, being visibly 'ethnic' and having researched the community, albeit at a distance, might succeed where they had failed,... at least in obtaining some basic ideas about the communities' health needs. Ironically, the only thing that I have in common with the local Asian and Chinese women, apart from my gender and skin colour, is the fact that I am an immigrant.

Realistically, I had as much chance of being accepted into the community as they had, since I do not speak or understand the various dialects, nor did I, at the time, have any respectable understanding of the different cultures and religions. Worse still, the communities in question had in recent years become especially suspicious of researchers as they were frequently researched and were beginning to feel like guinea pigs. Projects undertaken in the past, both research and community development, had only been partially successful, as they were usually conducted by White professionals who were accorded with polite but

restrained responses from the communities in question. On the other hand, the idea of using ethnic professionals to work with ethnic communities although successful in breaking down certain community/professional barriers was nonetheless limited in terms of overall impact, as the number of appropriately trained ethnic professionals tend to be few and far between. I realised that what was really required was an appropriate strategy to involve members of the community in a more direct manner. As an added advantage, this approach would allow members of the chosen communities to have some control over key processes and events.

Theoretical Approaches Taken

At this point, I accepted that although certain barriers (especially language and cultural) might not be completed eliminated, I would at best try to reduce or permeate a few through a participatory, collaborative approach. You will note later that rather than being a full participant I operated on the fringes as the facilitator and moderator of the process. On reflection, our work can be described as being both formative (research and development) and summative (evaluation). As the project evolved, information that was gathered was used to develop a programme which was implemented, refined and its impact, evaluated. Theoretically, it would be incorrect to place the project within any specific model or framework of qualitative research as the approaches, techniques and methods used were varied to suit the different aspects of the project

It would be fair to say that the general approach taken with the formative work (research and development) falls within the framework of New Paradigm Research (as elaborated by Reason and Rowan, 1990) since there were elements of collaboration and participative action at various levels. On the other hand, the approaches taken during the summative stages (evaluation) can be linked to the Transaction Model of Evaluation, (as referred to by Patton, 1990). Within these broad frameworks, a flexible approach was taken and elements of both Responsive and Illuminative evaluation models were included. It might be worth mentioning that the above theoretical models share a number of common ideologies.

The key elements that underpinned our work during both the formative and summative phases were guided by the core principles outlined by Patton (1990 pp124-125).

Method and Techniques Used

Regarding the methods and techniques used, a multiple method approach was adopted, especially in terms of data sources. Techniques used to collect and record information included, observation (both participant and non-participant), focus group discussions, semi-structured interviews, self evaluation records, field notes and diaries (both electronic and non electronic). The key events and outcomes were systematically recorded, evaluated and interactively used to develop the project.

The processes involved in the development of the project was mapped after the completion of the core project when we retraced our steps to take account of our achievements. In practise, certain processes were not pre-planned but were allowed to evolve as the project grew. My task as the researcher/evaluator was essentially to co-ordinate, oversee, review, analyse events and to ensure that the work was being guided along professionally acceptable standards while the key participants viz: the professional health personnel and members of the selected communities were responsible for the work at grass roots level.

The Research Process

The starting point for me was to attempt a process of dialogue with members of the chosen communities. I knew that the older members (who were my target population) relied on the younger ones for information, interpretation and other similar support in terms of

functioning within a society they knew little of. My initial plan was to make contact with the younger women with a view of channelling messages via them to the older. I came across my first obstacle in the form of the so called 'gatekeepers' of the communities. Quite simply, in order to gain credibility, I had to first win over the support of the gatekeepers, who were usually the wealthier business men, certain respected members of the ethnic communities (mainly priests and religious leaders) or those individuals who were 'well known' in the community (usually the people who organised local community activities and events).

With considerable effort, meetings were arranged with the gatekeepers and my plan to recruit young women from the ethnic communities, to be trained as field researchers, was explained and promptly rejected. It was made clear that the initiative would not be supported unless accompanied by something more tangible (and directly beneficial to the community) than a research report. This initial reluctance to participate in our proposed work forced us to consider an end service or social programme. Since the health authorities were desperate to attract ethnic women to the screening services, they agreed to fund the development of an additional health education programme, specifically designed to suit the needs of these communities.

In exchange for basic health information, we promised to develop and implement an appropriate health promotion programme, but the key areas to be covered were pre determined by us i.e. breast and cervical cancer, as these were the health authorities current area of concern. This arrangement was acceptable to all concerned. Once this initial barrier was overcome, it was fairly easy to recruit 11 young 'lay' women from various ethnic (Pakistani, Indian and Chinese) and religious backgrounds to undergo basic training in areas of research. In addition to English, the women selected were also able to speak various ethnic languages including a combination of; Urdu, Punjabi, Hindi, Cantonese, Hakka and Mandarin.

The women who became who became known as 'community health workers' (CHWs) were briefed about the main elements of the proposed research approach and were given basic training on the art of interviewing, the finer points of observation, listening and strategies for recording relevant data (both in terms of semi-structured interviews, diary notes and self evaluation sheets). Although at the end of research training, I was confident that the women would be able to cope with the practical aspects of fieldwork, I was somewhat apprehensive about the nature and quality of data returns as I had not worked with 'link' persons, previously and had no idea what to expect... it was slightly different from using professional research assistants or trained fieldworkers...the CHWs had not done this type of work before and they were to become my eyes, ears and representatives of my thoughts!!

Nonetheless I was confident that systematic monitoring of the fieldwork would identify discrepancies as they occurred. This strategy allowed us to refine in the work of the women as they progressed and there was little doubt of their competence by the end of the initial field research which became known as the pre-programme survey. Indeed being accorded with the responsibilities of a professional researcher, inspired the CHWs to be extra careful and honest about their work as they were eager to impress. Responses from the community members were equally positive and the majority of those approached readily agreed to participate in the research. Being from similar backgrounds the CHWs were able to empathise fully and to understand the isolation, insecurity and marginality experienced by the community participants. A trusting relationship was easily formulated once the purpose of the work was explained.

Despite being relatively small in scale and somewhat focused, the pre- programme survey succeeded in providing useful indicators with respect to the knowledge base of the target groups, their health behaviour and beliefs and areas of need. Needless to say, this

information was valuable for development of the health education programme that followed. The programme included various aspects:

* a training component to prepare the CHWs for health education work

* the evaluation of the training

* the design of appropriate health education messages (which would form the core of the community health work)

* the implementation of the health education programme

* the evaluation of the programme in terms of it's impact on the community.

Given the extensive nature of the processes involved during each of the above, I will not dwell on the details, but will attempt to provide a snapshot of some key events.

The Programme Development and Implementation (3 strands : training, implementation and evaluation)

i Training...

Using a participatory approach, a core training programme which covered relevant information relating essentially to breast and cervical cancer and screening services was designed by health promotion professionals with input from the CHWs, to ensure appropriateness, cultural sensitivity and relevance. In addition, a third dimension was included ie: aspects relating to healthy eating and diabetes. Since a vast majority of participants had indicated a desire for information such information during the pre-programme survey and it was felt appropriate to include this aspect.

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 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. This allowed the CHWs the opportunity to evaluate the local services in terms of their own communitie's needs.

In order to assess the impact and the extent to which the training programme had achieved its aims, the evaluators decided that it would be most appropriate to conduct various assessments during the training period; pre-training, mid-training, post-training and an evaluation during the fieldwork to establish the suitability of the training in terms of practical application. A combination of techniques including, semi-structured questionnaire, focused group discussions and participant observation were used to collect data. The trainers' 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 and trainers were confident that the CHWs were appropriately equipped to conduct the proposed community health work.

ii Programme Implementation (18 months)...

During the course of the programme, 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 the health work which was initially confined to 'known' community centres or 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.

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 difficulties, the CHWs were extremely successful in reaching and working with more than 2000 women from the target communities, over a period of 18 months.

iii Evaluation...

As with the training, the programme implementation (community work) was also evaluated at various stages by conducting semi-structured interviews with programme participants and focus group discussions with CHWs, trainers and health professionals. In particular, 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), conduct self evaluation (issues raised, referrals made) and record future work .

The sheet guided CHWs to operate in an organised and semi-formal 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 communities but also assisted in the smooth management and monitoring of the programme, especially during the initial stages. The evaluation 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 of the community.

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. The CHWs had the difficult task of ensuring that the same people who participated in the pre-programme survey would be willing to participate in the post- programme one so that matched sampling analysis could be done. The response to the latter was not fully successful and as a result a different strategy had to be used to generate the sample for the post programme survey. Although the CHWs assisted in setting up the post-programme survey, it was felt appropriate that the interviews be conducted by women who were not involved with the community work. Six specially trained Asian and Chinese interviewers who were recruited to conduct the interviews.

Key Outcomes

Overall, it is fair to conclude that not only had the programme which commenced as an exploratory research 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 population's 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 some.

It is often difficult to measure lifestyle change or direct impact of programmes, but the approach taken allowed us to obtain the true feelings of all those involved (community members, CHWs, professionals) and in a sense the participants not only assisted in the development of the programme but also became the key evaluators. 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 participants had already done so. Comments made by participants during a post-training evaluation indicated that many were able to understand the importance of changing their health behaviour and lifestyle and in addition, were able to appreciate the importance of doing so.

Conclusion

So why had we succeeded when other health professionals had failed?...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 others behaviour and expectations, only if we (the professionals) will give them (the lay community) a chance to become involved. If we can be less traditional and more flexible, if we can stop for a moment to listen rather than believe that we have all the answers and most important, if we reach out...

The project was a unique learning experience, not only for the target communities but also for the CHWs and the professionals (trainers and project leader). In particular, the regular group discussion meetings which were 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.

Ultimately, the project not only succeeded in building beneficial links with sectors of the local minority ethnic community and developing the skills and confidence of a group of lay women (CHWs), it also opened up an avenue for further work in this area and the development of similar effective initiatives that will make mainstream services more accessible to other marginalised groups in Scotland.

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