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Engaging communities in health intervention research/practice

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Asking communities to participate in health intervention is an increasingly popular strategy in public health and health promotion. The Community Health Educator Model, developed through a series of Participatory Action Research (PAR) projects in cancer screening in the UK during the 1990s, is a participatory health intervention model that emphasises community engagement. Although the model has been adopted by many health districts in the UK, little is known about the effectiveness of its appropriation; crucially, how researchers/practitioners engage with communities has seldom been reported. This paper presents the author's reflection on her experience in developing a set of community organising tools to respond to the diversity found in communities in practice. It suggests that engagement can be enhanced if the contingent and constructed nature of the concepts of 'ethnicity' and 'community' in the real world can be better understood. Researchers and practitioners need to cultivate a tolerance to difference and ambiguity so as to negotiate the ever-shifting boundary of engagement.

Keywords: engagement; community; ethnicity; health intervention

Introduction

The concept of community participation in the health promotion literature is often associated with the Alma Ata Declaration (WHO 1978) in which 'self reliance' and 'self determination' and the full participation of the community in health matters—be it in planning or implementation—are seen as prerequisites for successful achievement of health goals. The zeitgeist of communitarian claims to social justice through active participation of citizens, the emphasis on a bottom up rather than top down approach required by the new health promotion movement (WHO 1984), decades of debates on inequalities in health (Townsend and Davidson 1982, BMA 1987, Whitehead 1987) and the development of the community health movement throughout the 1970s and 1980s, as well as recent health policies (e.g. DoH 1999a, 1999b, 2002) have provided fertile ground for the emergence of community participation as an essential component of modern public health research/practice in the UK.

Recruiting lay people to deliver health education is not new. The concept of 'lay health educators' (LHE) was first reported in the late 1970s (Sabler 1979) and has proliferated throughout the last two decades (e.g. Eng and Smith 1995, Altpeter et al. 1999). The CHE model developed by the author through a series of three participatory action research (PAR) projects in cancer screening during the 1990s is a considerable extension of the lay

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health educator concept. A sustain research effort has enabled the CHE model to be grounded on a set of principles and practices that aligns with the new health promotion movement (WHO 1984). Its practice is characterised by the emphasis on empowerment through capacity building rather than only the improvement of service uptakes. It is, therefore, a model of participatory health intervention which emphasises the need for critical engagement (Chiu 2004).

Critical engagement means that members of communities are systematically involved through the recruitment of the CHEs in all aspects of planning, implementation and evaluation of health promotion programmes. These activities are organised through a three-stage iterative action research process: Stage 1. Identification of needs; Stage 2. Development of health intervention; Stage 3. Implementation and evaluation (see Figure 1).

Despite the adoption of the CHE model by many UK health districts, adopters (other than the author) have generated very little evidence about its effectiveness. More importantly, learning about the participatory process—crucially how researchers or practitioners engage with the communities—has seldom been reported. The process of recruiting lay people from an ethnically diverse community to participate in health intervention research can be challenging. Much of this challenge stems from difficulties in operationalising the concepts of ‘community’ and ‘ethnicity’. The following is the author’s reflection upon the way in which a set of community organising tools, i.e. ethnicity, language, and identification, was developed in response to the fluidity and diversity found in practice, drawing examples from the PAR projects mentioned above. The implications of using these tools to research/practice are also discussed.

**Background**

The project that gave birth to the concept of the Community Health Educator was the communicating breast screening messages to minority ethnic women (BS) project (Chiu 1993). CHEs were conceived of as bilingual women recruited from eight minority language/ethnic communities. In the course of this project, they were involved in the assessment of needs, planning, implementation and evaluation of a health promotion programme through a three-stage research cycle mentioned above (Figure 1). The bilingual women who volunteered to be trained as health educators had a high educational level and had mostly either been engaged in the health services as practitioners (e.g. nurses or health advocates) or had previously participated in community activities. They actively

![Figure 1. The Community Health Educator Model in a three-staged action research framework.](image-url)
participated in all aspects of the project. In particular, they contributed to the development of a unique training programme which consists not only of technical knowledge of cancer screening but also community development skills.

The CHE model was subsequently tested in the primary care setting between 1995 and 1997. The *Woman To Woman Project* focused on the promotion of access to cervical screening services in primary care among women from six minority ethnic communities residing in three health districts. Working with six general practices, CHEs were recruited and trained to identify health education and promotion needs within their respective communities using the focus group method. Based upon analysis of the focus group data, a programme of health promotion was formulated in conjunction with the six general practices. As well as women who were eligible for screening in the communities, non-attenders to cervical screening were specifically targeted. CHEs not only carried out awareness-raising sessions with women, but also supported non-attenders to access services. The project uncovered the significance of professional practice in influencing uptake among minority ethnic women. Steps were then taken to support change in the professional practice of the smear takers. Improvements of uptake, professional practices, and clinical communications were reported (Chiu *et al.* 1999, Chiu 2004).

The third project *Straight Talking* (2000–2002) aimed to improve access to breast screening information and services among not only minority ethnic women but also among White/English women from socio-economically deprived areas. CHEs were involved explicitly as co-researchers from the outset of the project. While the general methodological approach of this project was similar to previous projects, the evaluation of the intervention programme took a mixed method approach in which both quantitative and qualitative methods were used to measure the effectiveness of CHEs. It has been found that CHEs from communities with concentrated populations in the localities (the Sylheti/Bangladeshi and the Mirpuri/Pakistani) were more effective than those CHEs whose communities were scattered across districts (e.g. the Chinese/Cantonese) or whose non-attenders did not live in their CHEs’ neighbourhoods (the White/English). These disparate results indicate the contextuality of the concept of ‘ethnicity’ and ‘community’ (Chiu 2002), and suggest that concepts such as ‘identity’ and ‘networks’ might be key additional conceptual tools for engagement that require further exploration. And it is to a reflection on the development of these organising tools for engagement that I now turn.

**Using ethnicity as a community organising tool**

While conventional researchers formulate sampling strategies to study particular populations, PAR researchers face choice points as to which communities to involve in the projects.

In the Breast Screening project, which took place in an ethnically diverse city in the North of England, we were immediately faced with such a choice, which was constrained by available resources and the funder’s brief. At the time, the mapping of inequalities by epidemiologists (Balarajan and Soni Raleigh 1991, HMSO 1992) provided the first nomenclature to describe ethnicity and health inequalities, i.e. Asian, African Caribbean and White. Despite its simplicity, in the early 1990s this nomenclature influenced which sub-populations health intervention research should be targeted at. However, we found the two categories, i.e. African Caribbean and Asian, were too crude to inform our strategy for involvement on the ground. The former encompasses people from Jamaica, Trinidad, Haiti, Dominican Republic, as well as people from the whole of the African continent.
The latter includes Indians, Pakistani, and Bangladeshis but in practice might exclude Sri Lankans. These short-hand terms also tended to ignore the complex socio-political and migration histories of these minority groups, and hence the huge ethnic, linguistic and cultural variations that can be found among them. For example, we found the Ugandan Asians speak English, Gujarati, Hindi and/or Punjabi; Depending on their birthplace and education, the Vietnamese might speak French, English, Mandarin Chinese or Cantonese; members of the Chinese community might speak English, Cantonese or Mandarin; also most of the older members of the community in Britain speak Hakka as their mother tongue and Cantonese as their second language.

As we encountered this linguistic and cultural diversity, we began to see the potential of using language as a community organising tool. In addition, as language, be it spoken or written, is central to the subject of our research (communicating breast screening messages) and the products of our study (producing a community health education model and materials to support it), we decided to give it primacy over ethnic category. This approach has not only proven to be useful in accessing a diverse community, but has also exposed the inadequacy of the official ethnic categories which simply do not reflect the multi-dimensionality of language, ethnicity and culture that we have encountered in practice. As a result, a total of eight language/ethnic groups and six language/ethnic groups were involved in the BS and W2W projects, respectively (Table 1).

We have also found that the use of the term ‘White’ as an ethnic group in health intervention research/practice has serious implications for the policy commitment to address inequalities. As Bhopal and Donaldson (1998) have argued, the term ‘White’ includes persons of many varied ethnic backgrounds such as Scottish, English, Irish and non-British European including Greek, Spanish, and Polish. Indeed, in the Straight Talking project, the difficulties of the White/English speaking CHE who has a Scottish background in engaging the travellers and other white communities demonstrated precisely such complexity. Lumping these groups together as White and using the term as the basis of comparisons with non-white minority ethnic groups obscures great diversity and undermines the very needs of those who are socially and economically disadvantaged.

Using language as a community organising tool

The strategy of using linguistic rather than ethnic categories as an organising tool found resonance with Cohen’s view of the meaning of community based on Wittgenstein’s pragmatic philosophy that our interpretation of terms should be based on the practical purpose of their use (Cohen 1985). This approach allows us to recognise the multi-lingual nature of many minority ethnic communities and the potential of CHEs recruited to engage with a wider section of their respective communities. For example, other things being equal, a trilingual Chinese CHE who speaks English, Cantonese and Mandarin will be more effective than a bilingual one. However, this tool was put to the test in the W2W project.

Predicated on the wider relevance of the research results, the research brief was to involve the larger minority ethnic groups in the designated localities, e.g. South Asian, African Caribbean and Chinese. However, while we found that the Pakistani community was relatively large in the research site, the African Caribbean and Chinese communities were rather small. Only a few African Caribbean families and a Chinese community of around two hundred were to be found in the area. In order to satisfy the national relevancy of the project, we decided to expand the research site into neighbouring
Table 1. Various groups involved in the three PAR projects between 1990 and 2002.

<table>
<thead>
<tr>
<th>Project</th>
<th>Ethnic (language) groups involved</th>
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<tbody>
<tr>
<td>Breast screening</td>
<td>African Caribbean (English)</td>
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<tr>
<td>WTW</td>
<td>Bengali (Syhleti)</td>
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<tr>
<td>Straight talking</td>
<td>White (English)</td>
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<td>Chinese (Cantonese)</td>
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<td>Sikh (Punjabi)</td>
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<td></td>
<td>Vietnamese (Vietnamese and Cantonese)</td>
</tr>
</tbody>
</table>
districts where some of these communities could be found. These surrounding districts had
other small but needy communities such as the Somalis and the Yemenis and local
stakeholders were keen to have them involved in the project. However, extra funding to
support the involvement of the Somali community was unavailable as they were not
defined locally or nationally as an ‘ethnic’ group. By contrast, although the Yemenis were
also not identified as an ethnic group by the OPCS census, they were included in the
project because they were officially recognised locally as a distinct and separate ethnic
group. Their local socio-political infrastructure was well established to enable them to
negotiate with agencies and authorities for resources.

Another small ethnic group involved in the project was the Vietnamese. Despite the
label, the members of this group were mostly ethnic Chinese in origin. They nevertheless
defined themselves as Vietnamese rather than Chinese. This self-identification might seem
illogical to those who contend that the meaning of ethnicity derives from shared
ancestry, language and culture. However, if we understand how resources were allocated
to minority groups before the introduction of the Single Regeneration Budget, we can
understand the reason for this self-identification. Had they been defined as Chinese, they
would, at the time, have had to compete with the Chinese for resources under Section 11
funding.²

The above observations highlight some of the limits to involve minority communities
based on either the linguistic and/or ethnic categories, and draw our attention to the fluid
and socially constructed nature of ethnic identities. While the everyday articulation of
ethnic identities is around ancestry, culture and language, these are all subject to change,
redefinition and contestation, both by individuals and the collective (Fenton 1999).
Furthermore such strategic distinctions are often made to enhance social and political
advantages (Bourdieu 1977).

Using identification as a community organising tool

Although we were fully aware of the ethnic diversity and linguistic variations that could be
found among target minority ethnic populations and sought to organise our recruitment of
CHEs based on language groups, hoping these would correspond with ethnic groupings,
some aspects of the CHEs’ involvement remained problematic. At the beginning of the
WTW project, an Arabic speaking CHE was recruited through the existing network of
staff of the health authority to work with the Arabic-speaking Yemeni community.
However, we discovered that the CHE was in fact not a member of the local Yemeni
community but was of Pakistani origin and had grown up in Saudi Arabia. Being an
Arabic-speaking Muslim, participants in her focus group had no problem in
communicating with her, yet the cultural barriers were obvious. They did not seem to
respond to her questions spontaneously. This infelicity was communicated formally to me
by the Yemenis’ community worker after the first focus group, who then suggested that
this CHE should be replaced by one of the women in the Yemeni community.

Although recruited through the Vietnamese community centre, the Vietnamese/
Cantonese speaking CHE had also reported similar difficulties. She was quickly identified
as a Southerner by participants in the focus group who mainly came from North Vietnam.
The author observed that in the focus groups her attempts at facilitation were ignored, and
responses were often directed back to the author, rather than to the CHE (Chiu 2000). The
CHE was demoralised by the lack of identification of the women of communities with her
and wished to leave the project. Only after the (Vietnamese) community centre manager
offered his unstinting support for her was she willing to continue her involvement with the project.

In examining the transcripts of the focus groups facilitated by these two CHEs, the majority of the responses obtained were prosaic and lacked the richness of personal stories that emerged from other groups. In contrast, recruited from the practice neighbourhood where the majority of the Pakistani communities resided, the Mirpuri/Pakistani CHE appeared to have built trust and rapport with many members of her community. Consequently, she was able to recruit more women to the focus groups, and engage them in articulating their health needs and expressing some of their most intimate feelings about a whole range of sexual health issues (Chiu and Knight 1999).

The assertions of ethnic identities and the symbolic marking of difference (language, culture and origins) observed above highlight the central role that identification plays in engagement. Identities are not unified; the contradictions within them require constant negotiation (Woodward 2002). The Vietnamese community centre manager seems to have been involved in a difficult negotiation in saying that North and South Vietnamese are the same, while the women were saying that they are fundamentally different. In engaging communities, the mismatches between the collective and the individual level can often be found to arise at the boundary between the collective assertion of group identity and the individual’s day-to-day experience of shared language and culture.

**Implications for practice**

Although the concept of community is a contested one (Jewkes and Murcott 1996, Nilsen 1996), its objective manifestation could be observed in institutions and organisations that existed in the locales. That communities do exist is evident by the fact that we were successful in recruiting CHEs through the voluntary sector, community centres, mosques and temples etc. However, on another level, our assumption that CHEs would be able to reach non-attenders on the Did Not Attend (DNA) list by virtue of their community membership was challenged. In the Straight Talking project, the Cantonese/Chinese and the English/White CHEs had little success in gaining access to their respective communities in comparison with the Mirpuri/Pakistani and Syhleti/Bengali CHEs, who identified that two major factors for their success were: (1) that non-attenders could identify them as a member of their community through a network of relations, (2) that both they and the non-attenders resided in the same neighbourhoods.

Due to the scattered nature of the Chinese community, to gather DNA lists from practices and travel across the city to meet women on these lists demanded considerable resources. It was therefore practically impossible for the Chinese CHEs to access a comparable number of non-attenders to that accessed by the South Asian CHEs. The English/White CHE reported that her visits to non-attenders were met with hostility and suspicion. Her conversations with them often took place only on doorsteps. We learned from these results that the effectiveness of the CHEs to reach non-attenders could not be assumed by virtue of their ‘perceived’ shared community membership. Social and institutional identification, social networks and geographical locations might all play a part in engaging successfully with communities. In subsequent projects, the strategy used to maximise CHEs’ acceptance by non-attenders of their respective communities was to present the CHEs as a member of the general practice staff to invoke institutional identification (the patient–practice relationship) on the part of non-attenders.
Conclusion

Engaging communities in health intervention research/practice requires us to be vigilant about the objectification of the concepts of ‘ethnicity’ and ‘community’. The problematic encounters described above have revealed that ethnic identities are fluid and situational. Our strategy for initiating engagement, although influenced by existing official ethnic categories were also determined through a process of negotiation and compromise between top-down interests, the practitioners/researchers’ judgement, and local conditions.

The fluidity of the concepts of ‘community’ and ‘ethnicity’ that we found in practice has led to the development of a set of organising tools that take account of language diversity and ethnic identities as well as institutional and organisational identification. However, tools are tools, and their effectiveness depends on how they are used. Researchers need to cultivate tolerance to difference and ambiguity, in order to negotiate these ever shifting boundaries of engagement. In addition, our experience has taught us to be mindful of our expectations of CHEs. Our easy assumption that their ethnic identities (as defined by self or others) and linguistic abilities would lead automatically to wider engagement may sometimes be misplaced. Institutional support and a programme of capacity building are needed to ensure effectiveness.

Acknowledgements

The author thanks all minority women who volunteered as Community Health Educators in the three PAR projects, and is grateful for the support of the NHS Cancer screening programmes of the U.K. and their activities.

Notes

1. While there are currently five CHE projects in Leeds, the CHE model has also been adopted, in various forms and under different names, by Manchester, Ealing, Slough, Lanarkshire, Luton, Bradford, Leicester, and Sheffield.
2. Section 11 funding distributed State resources to distinct ‘ethnic minorities’ throughout the 1980s and the early 1990s under the Government’s Urban Programme. This funding programme came to be seen as divisive and as potentially depoliticising black oppression. The programme was terminated in 1995 and replaced by the Single Regeneration Budget.

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