Planning Healthy Communities

A Guide to doing Community Needs Assessment
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This Manual has resulted from many people’s effort. Those involved are listed below, along with a summary of their role. The period of their involvement is indicated in brackets.

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what, why, how:
assessing needs
for planning a
healthy community

Section One
SECTION ONE: What, Why, How

Assessing Needs for Planning for a Healthy Community

1. What is a Needs Assessment?
2. Why Information is Important
3. A Smorgasbord of Methods
4. Examples of Community Needs Assessment in Action
CHAPTER 1 - Introduction: What is a Needs Assessment?

Welcome to this Manual! In it we hope to provide you with:

- a framework within which to collect information for planning healthy communities;
- tools to enable you to do this;
- the confidence to do your own community research or to work with researchers so that you feel you can understand the process and make a contribution to it;
- an idea of the benefits and pitfalls you can expect in setting about this type of activity.

The video that accompanies the Manual is intended to elaborate on the first and third of these aims. The manual and video have been prepared primarily from the perspective of community health centres and their workers but will be of use to a variety of people who are keen to work towards healthier communities, including:

- welfare workers;
- local government community services workers;
- people working with projects such as Healthy Cities and Healthy Localities;
- members of community self-help or environmental groups.
Planning healthy communities depends on an assessment of the needs of particular communities. Many communities around the world are putting effort into assessing how their lives and environments can be made healthier (sometimes called 'community diagnosis'). Lessons emerging from these exercises are showing that such assessments have to move beyond an analysis of illness in the community and the requirement for services, to a more positive perspective that looks not just at how illness is prevented but also at how health can be maintained and created. We are also learning that the methods of assessing community needs have to be more sophisticated than in the past, and need to go beyond straight description to analysis and interpretation. This Manual will provide you with a guide to the complexities of this process and assist you in getting over some of the hurdles you may face.

One of the crucial points made throughout this Manual is that assessing needs and planning healthy communities is a value-laden process, that cannot and should not be expected to be value-free.

Users of this Manual will benefit from an introduction to the development of community health services and the recent emergence of the new public health in Australia. A basic feature underpinning these developments has been the pursuit of health equity.

**Health Equity**

*Health Equity is not the same as Health Equality. While health equality can be quantified, equity implies concepts of ‘justice’ and ‘fairness’ that are not captured by statistical measures (Labonte 1987).*

In 1986 the World Health Organization launched its ‘Health for All by the Year 2000’ initiative.

Globally, this implied an obligation on behalf of the industrialised nations to help improve the health of communities in the third world.

Nationally, it meant that countries like Australia had a duty to remove health inequities between groups within the community.

It is now common knowledge that Australia cannot be regarded as a society where no group is disadvantaged in its access to health.
Women suffer far more chronic life-threatening illnesses than men. However on the average men die 7 years earlier than women (ABS 1978:24-5). Studies over the last few decades have shown that in Australia the poor have worse health than those with higher incomes (Bates & Linder-Pelz 1987; Baum & Abbott 1989). They suffer from more minor illnesses such as stress, sleep disturbances, lack of energy and colds. They have a higher incidence of debilitating diseases such as high blood pressure and cardiac disease, and they have a lower life expectancy than Australians with higher incomes.

In Australia the group with the worst health of all is the Aboriginal community.

| Aboriginal Australians have an expected life span 20 years less than non-Aboriginal Australians. |

All sections of the community should have equal access to the essentials of our society which include:

- unpolluted air and water;
- nutritious food;
- appropriate housing;
- adequate transport;
- meaningful leisure and work activities;
- social support and a pleasant environment;
- educational and employment opportunities.

To achieve health for all in Australia, it is not enough to do what we have done in the past by putting resources into ad hoc measures to relieve the problems caused by structural inequalities within society. To achieve true health equity, we have to change those structures.
Health equity is not the same as health equality. Health equality would mean that everyone had the same health status. There will always be genetic and lifestyle factors that prevent this. What we can do is to remove social barriers to good health and in this way achieve health equity.

**Community Health, Health For All and The New Public Health in Australia**

A review of community health history highlights the need to plan services on a population basis.

The community health movement in Australia originated with the ambitious national program launched by the Whitlam Labor Government in the mid-1970s (NHHSC 1973).

It was intended to redress inequities in the provision of public health services and develop comprehensive systems of health care that would be community based and focus on preventive rather than curative care.

The stated objective of the Community Health Program was ‘to encourage the provision of high quality, readily accessible, comprehensive, co-ordinated and efficient health and related welfare services at local, regional, state and national levels’ (NHHSC 1976). Key features of the program were: an emphasis on preventive care, interdisciplinary co-operation in the provision of services, community involvement in the development of programs, and ongoing evaluation of services. Priority for service provision would be given to ‘areas of greatest need’, both geographic and functional. A review of community health services in 1976 recommended that the Community Health Program continue, and specifically that community participation at a variety of levels be encouraged, that systems for monitoring the effectiveness of programs be developed, and that greater emphasis be placed on health education and health promotion at the community level.

Despite this review, Federal funding of this program ceased in the late 1970s, and thereafter State development of community health services has been uneven. In Victoria and South Australia, there is a network of community health centres that are community-managed and attempt to have a preventive focus to their work. In other States, community health services are more akin to domiciliary care services and concentrate on tertiary care. A national review of the Community Health Program in 1986 concluded that:
The second impression of community health was a degree of conservatism that was not in accord with the intentions of the original program. That program was envisaged as shifting priorities in health from expensive, specialist, curative services to community-focussed primary care services with an emphasis on primary prevention and community participation (ACHA 1986).

Part of the reason for the gap between the rhetoric of community health policy and the practice is that, for a variety of reasons (including lack of resources, inadequate training, pressures of service delivery), community health services often do not conduct adequate needs assessments. Policy statements on community health at both Federal and State levels have advocated ‘need’ as the basis of service delivery but have given no guidelines for how it should be assessed (Bollen et al 1984; SAHC 1984; SCHRU 1987). Armstrong (1985) has warned that the lack of adequate needs assessment research ‘threatens the possibility of a successful program’.

Recent thinking about health promotion and public health is encouraging community health services to develop further innovations and to take account of criticisms of their primarily curative orientation. Currently, the philosophy advocated by the Ottawa Charter on Health Promotion (WHO 1986), and the World Health Organization’s Health For All by the Year 2000 strategy (WHO 1978), are used as the underpinning of many health promotion programs in Australia. The themes advocated in these documents are:

- health equity;
- definition of health as being much more than the absence of illness and being concerned with physical, mental and social well-being;
- healthy public policy with the aim of ‘making healthy choices the easy choices’;
- action from all sectors of our society to promote health rather than this being seen as the province of the health sector;
- when health is defined positively, the way we look at the health of communities changes - what we look for is not solely an absence of disease but we are also searching for factors that promote a state of well-being;
- encouragement of community involvement in planning and implementing health promotion;
- developing and strengthening a supportive environment for promoting health;
- reorienting services so that they put more emphasis on prevention.

The current emphasis in public health stresses the importance of accurately describing the community in which health workers are working (Ashton & Seymour 1988). It also puts emphasis on the importance of assessing the strengths of a community and producing positive examples of current practice - ‘models of good practice’ (Kickbusch 1989).

**What is a Needs Assessment?**

Needs Assessment is about collecting information that will give a good indication of the needs of a community and laying an essential foundation for planning healthy communities. A needs assessment will provide information that will help determine:

- the nature and characteristics of a community;
- whether current services and initiatives are responding appropriately to illness and are promoting health;
- where there is a gap in services;
- where new services are necessary to remove an existing health inequity;
- what environmental changes are necessary to improve health;
- how community structures are affecting health and the need for community development.
Needs assessment is, or should be, the key element in planning services that directly or indirectly affect the health of the community, such as recreation, transport, and city planning. Needs assessment may, of course, focus on particular activities, such as health services, but should see them within a wider social context. It can also highlight deficiencies in the environment and indicate ways in which changes to the environment of a community could improve the health of that community.

When to Assess Needs

Needs assessment provides information to use in the allocation of resources, the planning of services, and initiatives to promote health. Information from a needs assessment should be available when setting priorities, re-allocating funds or planning programs within a community health centre.

When there are inequities within a community, a variety of information is a convincing way to show those who fund services where resources should be concentrated. Needs assessment is a tool for community health workers to use in achieving a healthier community.

Community health centres may feel that doing a needs assessment survey in their area is beyond their resources. This thinking is often based on a wrong assumption, that needs assessments always have to be large, expensive exercises that require considerable resources and expertise.

In the next chapter, the role of needs assessment in planning is examined.

First, we must ask what exactly we mean by need in this context.

Need

| need: necessity; lack of something required or desired; extreme want; condition of deficiency (Collins Australian Pocket Dictionary). |

A large amount of literature has developed around the concept of 'need' and how it has been interpreted and used.
Four Types of Need

One of the most frequently quoted analyses of need is that of Bradshaw, who lists four different types of need based on how the need is identified (Bradshaw 1972:641-3).

Normative needs are the needs of a community defined by experts who judge what a community needs on the basis of their experience.

Felt needs are what the members of a community say they want, for instance through a community survey.

Expressed needs are those needs that have been expressed by members of the community, for instance by putting their names on a waiting list.

Comparative needs arise when one community lacks services that are provided in another, similar community.

Bradshaw clarifies the relationship between needs and how they are assessed; however the clarification does not help determine priority for, as Bradshaw acknowledges, there is no reason to suppose that a need identified by three sources has a higher priority than a need that has been identified by only one source.
Basic Needs

One of the more comprehensive lists of basic human needs, presented below, has been provided by The Australian Council of Social Services (ACOSS 1973):

housing
health (absence of disease)
education
material goods and services (including income and access to credit)
leisure
employment
mobility and transportation
opportunities to pursue and express personal values
civil and legal rights and services
political participation and power
personal social services
safety

Every one of these needs has a bearing either directly or indirectly on health. Poor housing can lead directly to poor health when the house is damp, cold or subjected to such environmental hazards as lead or asbestos. Indirectly, poor housing will lead to poorer health when the occupant is stressed by the poor environment and by frustrating and unsuccessful efforts to achieve a higher standard of housing. Similarly, unemployment can lead to poor health directly because of an inability to buy nutritious food, and indirectly because of the stress, depression and low self-esteem that it can involve.

Who Determines Need?

*Consumer and community participation in decision making about health is becoming widely recognised as an important element for dealing with health policy challenges of the late twentieth century* (AHMAC 1988).
Clients must be involved in the process. Need provides the basic reason for each program; and the public which is to be served and which pays the bill should know the rationale and be able to have an input into the consequent setting of priorities.
Identification on needs then must be a public process. Feedback is crucial (SSCSW 1979).

If we look back at Bradshaw’s needs, we see that needs can be determined by the community (felt and expressed needs), by experts (normative) and by precedence (comparative).

All too frequently in our society, it is the latter two ways of determining needs that have been used as a basis of services.

Firstly, precedence alone has never been a good basis for establishing services. The existence of a service, possibly appropriate for one community, is not sufficient justification by itself for setting up that service in another community.

Secondly, expert opinion can be misleading. Experts may not see a full picture of the world from the limited perspective of their own area of expertise. They may not be aware of the dissatisfaction of consumers with existing services. Also the priorities of experts may not be the priorities of the people they serve.

Women in a Toronto housing complex rejected an assessment from the Public Health Department that they needed an awareness program about nutrition. Identifying their problem as a lack of control over food and living conditions, they asked for a community garden.
The community garden provided a number of benefits. Not only did the women gain control over their diet, the garden project also provided the impetus for them to work together as a group for their own benefit and for the good of the community. From their interest in the garden the women increased their knowledge of nutrition. On a wider front, with the confidence they got from the success of the garden project, they instituted programs to change the image of women on welfare (Labonte 1986:348).

What is the Difference Between a Needs Assessment and an Evaluation?

In needs assessment and program evaluation, information relating to health needs and social services are collected and analysed.

Whereas evaluations assess the relevance, adequacy and appropriateness of individual programs, a needs assessment looks at the overall picture and determines gaps in services, how existing services relate to each other, how well these services fulfil health needs, and the extent to which these services are known and used.
before
you
start

Section Two
Information is crucial to effective planning but decisions are rarely taken on the basis of information alone. Politics, changing circumstances, resource availability and other factors often shape events. This chapter will look at both valuable and dubious reasons for collecting information to determine need.

Valuable Reasons

To Bring About Change

As part of their work, community workers adapt to changing times and the changing needs of the community. This can mean abandoning favourite programs and embarking in new directions. Needs assessments can point the way but it is the workers who must be prepared to take up the challenge and consider how they want to change their practices. New information can be particularly helpful when an agency wants to change in a particular direction.

Currently, primary health care agencies are trying to increase the amount of their work that aims to promote health and to do this by focussing on populations rather than on individuals. Information about community needs is essential to enable them to do this effectively.

A review of needs is particularly important when new resources are available. Assessments conducted when there is little chance of change use up valuable resources. Conducting research heightens expectations and the community has the right to expect that an assessment will be followed by action. If nothing changes on the basis of the assessment, there will be community disappointment, as well as community disillusionment with research projects generally.

Education

New information, and the process of acquiring it, can encourage people to think laterally. Creative thinking is an essential part of innovative planning and the process of achieving healthier communities.
Information can challenge prejudice and be a powerful agent for change. In this sense, the process of assessing needs is akin to a community development exercise, whereby the acquisition of new knowledge goes hand-in-hand with an assessment of long-standing assumptions.

To Guide Policy Formation, Fund Allocation and Planning for Services, Programs and Activities Such As Community Development

*Without the Need Assessment input, health and human service programs stand little chance to weather the storm resulting from the pressures of vested interests, bureaucracies, and professionally determined needs* (Attkisson, Hargreaves & Howitz 1978:224).

Since federation, Australian health services have developed and changed in response to a variety of factors, including historical precedence, political ideologies, perceived need and profit.

A needs assessment can free decision-makers from the pressures of special interest groups. By providing valid new information, a well-executed needs assessment enables decision-makers to assess the validity of competing claims for resources.

For many community workers and researchers, the opportunity to affect policy and fund allocation on a National or State scale is a utopian dream. Information, however, can be a powerful tool for shaping the direction of local service planning and community-based health promotion.
The Noarlunga Healthy Cities Project used information collected in a community health needs assessment to form the basis of planning for a healthier community. For example, the community survey highlighted the importance of the local physical environment to local people and this enabled the project to develop or support initiatives that sought to enhance the environment.

To Prevent Costly Mistakes Setting Up and Directing Services

An assessment of community needs can be useful in deciding whether a program or service will be used or, more commonly, where it is likely to be of most benefit to the community.

An analysis of the demographic structure of a population within a region could help determine where a Family Planning Clinic should be located. It would be of less use in an area with a high proportion of women over fifty years of age than in one with a high proportion of teenage women and those under fifty.
Dubious Reasons

Without realising it, the community health worker can become involved in a needs assessment where there is a hidden agenda, or where the impetus for the assessment has been other than to provide information for change.

When this happens, health workers may find themselves with a needs assessment which has used up valuable resources but which has failed to have any impact. When researchers find themselves floundering, it is worthwhile to go back and discover what were the processes that led to the decision to do the research.

On the positive side, no piece of research is ever a total failure. There are always lessons to be learned. The process itself can be educative and it can assist in the forging of networks among workers.

There are possibly dozens of dubious reasons for doing a needs assessment. Below we mention several that have come to our notice.

As a Delaying Action

Beloved by politicians and governments. Decisions can be hard to make, and one way of avoiding them is to call for research into the problem. It delays action and, with a bit of luck, by the time the research is published it will have become someone else's problem.

To Use Up Available Money

A suburban unit of a government department heard that funds were available for research projects. Prompted by the availability of the money, they decided to design a needs assessment. Because the impetus was the availability of the money rather than the recognition of how the results of a needs assessment could be utilised, there were problems in the research design. After months of meetings, with those involved spending many hours trying to come up with an appropriate questionnaire, the project was abandoned.

Because Someone Else in a Similar Area is Doing One

The 'me too' syndrome. This is not to say that needs assessments should be avoided simply because someone else has already done one. The results of the first assessment may be used as a 'kick-off'
for the second. It is important to see how the needs assessments can complement each other, and to determine at the outset how the second needs assessment can add to the information that came from the first.

**Because There Are Personnel or Experts Available**

Again it is tempting to use resources, but not if the needs assessment is going to sit on the shelf and gather dust. It is always worth while to ask ‘Will the needs assessment change anything?’. If the answer is a reluctant shake of the head, then it is not worth the time and the effort of your experts.

**To Prove What Everybody Already Knows**

When health workers are aware of a need, it can be tempting to try and base that need on something other than their own perception. In the face of a difficult and unresponsive bureaucracy, this may be necessary. However, it may be that the documented experience of the health workers is sufficient to demonstrate the need for a particular service. This is a far more cost-effective method than conducting a full needs assessment.

Community workers from different disciplines in the Noarlunga area agreed the area needed a youth worker. Months were spent designing a community survey to prove the need before the health and community workers realised that amongst themselves they already had the necessary information to make a submission for funds for an area youth worker.

**As a Ticket to Legitimacy**

This is a little different from the above reason. When research is used as a ticket to legitimacy it is used to ‘prove’ that what is being done is what is needed. This type of research can be recognised by the narrow scope of the research design and the ‘leading’ nature of the questions.

Research can also be used as a type of credential; another item to be added to the curriculum vitae or to the record of a Centre.
A crucial aim of needs assessment is to collect information to assist decision-making. A summary of the range of information likely to assist planning for healthy communities is provided in Appendix 1.1.

Research to collect this information can take many forms and no one type of research is necessarily any more legitimate than any other. However, in different circumstances, depending on the information required, some forms of research are more appropriate to use than others.

Research is often divided into two kinds: **quantitative** and **qualitative**. This Manual recognises this convention. However, the distinction is often made in terms of 'opposites'. In fact, quantitative research (so called) is considerably reliant upon qualitative aspects in many steps of the research task.

While medical research (which almost always talks in terms of quantities and numerical/statistical information) has made much greater use of the former, community health workers are finding that qualitative methods are often more suited to their needs.

In many cases it will not be either quantitative or qualitative methods that the researcher finds most appropriate, but a combination of the two. Good needs assessment usually relies on a variety of methods. Quantitative ones are often useful for gauging how widespread a particular phenomenon seems to be, while qualitative approaches enable deeper exploration of social life.

The following introduction is intended to assist health workers to gain a feel for some of the main strengths and weaknesses of the two approaches. Quantitative techniques are discussed further in Section 3. Qualitative research, and particular methods which utilise a qualitative approach, is discussed in greater depth in Section 4.

Figure 1, at the end of this Chapter, provides an overview of the way in which qualitative and quantitative methods combine to provide a basis for making decisions.
Qualitative Research

Although qualitative research does not produce "hard figures", it has developed rigorous methodologies, particularly through the work of social anthropologists in their ethnographic studies of tribal societies. Qualitative methods, in the hands of skilled researchers, can be powerful tools for understanding the social and cultural dynamics people are enmeshed in, which may not be immediately discerned either by casual observation or by survey methods.

Whether we decide to use qualitative or quantitative methodology, or a combination, depends on the nature of the issues involved, what the researcher is capable of, and what it is we hope to find out.

Qualitative research perhaps should be "bottom up" - a tool for seeing and understanding the world through the eyes of others. For this reason it is important that the researcher has a rapport with, and is accepted by, the community he or she is studying. Rapport and acceptance are the keys to fruitful qualitative research, but they also pose special, inevitable difficulties for the researcher.

Some qualitative methods have been designed for spending considerable time with people - both in interviews and for getting to know them in their communities. They may even require us to
take part in what people do, which would allow a fairly close acquaintance with people through informal social contacts. In this way we would derive information not only from what people tell us, but also from our observation of what happens. Such involvement would not only bring us to appreciate social problems from various perspectives, but it would also help to weigh their relative importance.

This form of research is clearly of great benefit to primary health care, where consumer needs and perspectives can and should provide the basis for program planning and delivery. Qualitative research, if properly carried out, can generate a range of data on attitudes and cultural perceptions. These data are indispensable for designing preventive and educational strategies that are socially and culturally meaningful to the community concerned.

**Qualitative research is often being done by community health workers without being formally labelled as such.** Community health workers, like social anthropologists, can become involved with a small community over time, becoming familiar with the social world of local community members, known and hopefully trusted by many in the community, and they may already take part in some community activities. From this experience, workers may gain clear ideas about the community needs, and even ‘hunches’ about specific ways of improving health. One research approach might be to follow up these hunches in a systematic manner.

Health workers have a unique opportunity to involve the local community in research that will affect that community. They may be able to draw people out to talk about their needs and aspirations. They can aim to present a more holistic view of the community using quantified research data, together with their own personal insights developed informally, as well as by using other qualitative methods. The entire experience of living and working in the community can become part of the data.

In contrast, outside consultants reliant upon existing official information and quantitative methods, with little if any local knowledge, can present only a deceptively ordered view of what is really a living, ‘breathing’, dynamic community.

Research methods and results should be accessible to the people whose lives are most affected by them. Community-based research calls for innovation: good qualitative research demands imagination and a certain amount of creativity.

The three most common qualitative research techniques, and associated theoretical issues, are explored in Section 4.
Advantages of Qualitative Research

- Qualitative research can bring into the open previously unrecognised problems and needs.

In the Marion, Brighton and Glenelg Community Health Needs Assessment, health and welfare workers revealed that many older men who had outlived their spouses lacked basic domestic skills, e.g. cooking.

- Qualitative research incorporates a large number of approaches (focus groups, in-depth or focus interviews, the normative group technique, the delphi technique, participant observation, and community healthwise consultation using Popular Education methods). It has the potential to generate a wide range of information, much of which could not be obtained using quantitative research methods.
• Qualitative research approaches do not restrict the interviewer to pre-set questions or to a particular and inflexible form of analysis. With them, we can explore an evolving understanding of ‘problems’ in their natural settings, together with wider social perspectives.

• The process of doing qualitative research can be a kind of end in itself. For many of the community workers in Marion, Brighton and Glenelg, the discussion about ‘needs’ provided an opportunity to take time to consider possible unmet needs in the community. In this way it was a learning experience for them as well as for the research team.

Qualitative Research and Statistical Validity

Qualitative research is sometimes criticised because it does not produce data that can be expressed statistically. Such criticism misunderstands the value and nature of qualitative research, and it often contains implicit and dubious assumptions such as the idea of ‘facts and figures’ being reliable and unarguable entities.

In the Marion, Brighton and Glenelg Community Health Needs Assessment, we employed young people to interview other young people hanging around local areas.

We chose young people experienced with ‘street’ groups as our interviewers because we thought they would have a better ‘feel’ for the people they were talking to and would be more likely to elicit useful and meaningful (hence valid) responses from them.
The type of information we obtained from these interviews could not have been obtained by using quantitative research, which has a different way of formulating and asking questions and of recording responses. The following quote from the Marion, Brighton and Glenelg Community Health Needs Assessment summarises our youth interview results.

Young people interviewed by their peers said that marijuana and pills are easy to obtain in the Marion-Brighton-Glenelg area, especially if you are young and have a friend who knows a dealer.

Drug deals are done on the Glenelg foreshore, at Westfield Marion and other popular public places, as well as in private homes. It seems unlikely that policing one location would reduce the availability of drugs to young people as they have a number of sources.

Most of the young people interviewed at Westfield Marion smoked ‘dope’ (marijuana) and some of them took pills. However, those interviewed were not a random sample and were selected because their clothes were similar to those worn by the young interviewers (young men: black singlet, open flannel shirt, jeans; young women; ‘bubble gum’ jeans, black shoes) and because they appeared to be hanging around the shopping centre rather than shopping.

All the young people interviewed rejected heroin (“no way”; “no, no, no”) and this supported the observation of youth workers in the Marion-Brighton-Glenelg area, that most of the young people stayed away from heroin. One youth worker said most of the young people had heard of someone who had been on heroin and the problems it had caused. Consequently they “wouldn’t have anything to do with it”.

The apparent rejection of heroin by these young people suggests that other young people may also take steps to avoid dangers when they are perceived to be very real. This possibly has direct implications for programs which aim to alert young people to the other health hazards such as drinking and smoking.

Qualitative information should not be reported as if it were quantitative. For instance if we had reported that 80% of all young people, or even that 80% of young people at the jetty, had smoked marijuana, we would have been misrepresenting our findings.
Although some quantification (frequencies, percentages, etc.) may be a useful aspect of some qualitative projects of a sufficient scale, or of a random design, generally speaking qualitative research should not be quantified. Moreover, it is often a blind trust in the validity and reliability of figures that insists on quantified data.

Reliability and validity of qualitative data are discussed in Section 4.

Generalisation and Qualitative Research

If qualitative information is not presented in a balanced manner, it can give a misleading perspective on social life in a community.

*In the Marion, Brighton and Glenelg Community Health Needs Assessment we received numerous reports from community workers alleging poor child rearing practices of some parents. The extent of this information was disturbing, and in the first draft of the Parents and Children report we put a great deal of emphasis on it.*

*Our Steering Committee pointed out that the emphasis of our presentation had made the problem appear more widespread than it probably was. The problem of apparent poor child rearing practices was finally reported in a more balanced manner alongside other data that showed more positive aspects of parenting.*

Quantitative Research

As the name implies, this is the type of research that quantifies, i.e. it provides information in terms of numbers or percentages.

Types of Quantitative Research in Needs Assessment

a) **Surveys**

Surveys can be used in many ways, for example to analyse the demographic and other characteristics of a group or groups of people. Asking a class of twelve-year-olds if they liked a movie may also be a survey. A 30-page questionnaire presented to 4000 people randomly selected from a population of millions is a survey. However, they do not have to involve questionnaires or even people. For instance, surveys may be taken of vacant beds in a hospital.
In Section 3 Chapter 1 there is a general overview of what we have called sample surveys. We have used the term ‘sample survey’ to identify those surveys which seek quantifiable information about a group of people believed to be representative of a larger group of people. Also in that section we explain the steps involved, including selection of samples, sample size, and questionnaire design.

b) ABS Census Data

The Census Data of the Australian Bureau of Statistics (ABS) is a valuable source of information which can be used to assess a community’s need for some services.

Results of ABS Censuses of 1981 and 1986 are available from the ABS analysed by Metropolitan area, Local Government Area, Federal and State Electorate Districts, Postcode, or, for an extra charge, a specific area you designate. The next Census will be in 1992 with some of the information available in 1992.

The smallest areas for which statistical data are available are called Collection Districts. A Collection District is a small geographical area averaging 350 dwellings in urban areas. The number of dwellings can vary quite considerably, and rural CDs and urban CDs containing parks, golf courses etc. may contain only a few dwellings.

All the information collected in the census is available for every CD in Australia (unless confidential). If for instance you wanted to know official reckonings on the number of children under 5 years, or the percentage of households with a car, in a particular area, you could obtain this information by identifying the CD or CDs which cover the area.

ABS will help identify CDs for specific areas - and they also have many publications which help explain the meaning and limitations of their data.

CDs can be combined in any way you like. However the most usual ways of obtaining information are by metropolitan districts, for example Adelaide and suburbs (called the Adelaide Statistical Division which includes 1715 CDs), Local Government Areas (for example, Marion or Glenelg), post codes, or electoral districts.

A common way of obtaining demographic data from the ABS is in the ‘seven page format’, which provides data on a whole range of demographic variables including age, income, house and car ownership, mortgages, family size and ethnicity. More detailed data (e.g. age groups by year instead of in 5-year groupings) is available
in a '21 page format'. For the 1991 Census, these will be available for each of many social groups, e.g. people of non-English speaking background. As it is not necessary to purchase all the pages in either of the formats, it is worthwhile checking to see what pages contain the information you require. Along with other government departments, ABS has been instructed to adopt a 'user pays' policy and information is no longer free.

Also available are tables in which variables are cross-tabulated with other variables, e.g. sex by occupation by education.

For community health research, the demographic data from a Census can be used to infer needs; for example, a large concentration of elderly people in an area may suggest the need for podiatry services.

A Social Health Atlas of South Australia is available from the South Australian Health Commission (SAHC) for $40. It includes the demographic and socio-economic status, illness and mortality, health and welfare service use, and air quality characteristics, mapped in colour, mainly by post code and region, for both Adelaide and South Australia as a whole. A black and white copy is available for $15. A major and commendable achievement, it forms part of the 'Social Health Strategy' series of publications of the SAHC. A glance at the Social Health Atlas identifies apparent concentrations; for example, areas where high percentages of the population live in Housing Trust accommodation, or where high percentages of people do not speak English in the home, or where single parent families predominate. The map in Appendix 1.2 depicts the distribution of single parent families in Metropolitan Adelaide as a percentage of all families in each post code area.

The map in Appendix 1.3 shows the Department for Community Welfare (now Family and Community Services) client intake.

So the Social Health Atlas clearly demonstrates, in a readily understood manner, the geographic expression of underlying social inequalities and their associated likely health consequences. However, do not neglect the 'cautionary notes' in relation to the limitations of these data and the dangers of their misinterpretation. For example, the number of households in a post code area varies considerably; hence relatively 'hot areas', where concentrations seem particularly high, can be generated artificially by very small numbers. Similarly, it may be that institutional data skews the overall result markedly, as a nursing home will boost numbers of elderly people and a boarding school will boost youth numbers. Note also that post codes are the smallest area for which information on health status and the use of health services is
available. Above all, read the maps together with their commentaries, and use the Tables in the Appendices for ascertaining relevant absolute numbers. Unfortunately, in 1990, South Australia was the only state for which such an Atlas was available.

The ABS will, for a price, provide individual coloured maps on specific population characteristics of specified areas - but as these costs rose 300% in 1989, you may try your local State library, for in SA these maps were free of charge that year. Other Government departments may also have C Data 86 (a census map computer program based on 1986 census data) and they may be willing to provide maps - or, in SA, ask community health research units.

c) Other ABS Data

ABS collects a wide range of statistics in addition to Census data. Particularly useful for health research are mortality figures, hospital in-patient separations by Local Government Area, and economic data, (e.g. unemployment figures and average weekly earnings). These statistics can be a useful supplementary resource in assessing the needs of local areas.

From time to time the ABS does surveys on specific topics. In 1977/8 and 1983 they conducted a national health survey which will be repeated in 1991. (Those results will not be available until 1992 and will not provide local data).

![Map of ABS Census map showing Collection Districts for the Glenelg area of Metropolitan Adelaide.](image)
d) **Data from Other Organisations**

Government departments can provide statistical information about clients and their characteristics; particularly useful are data from Housing Trusts or Commissions, Welfare Departments, Drug and Alcohol authorities, Family Planning Associations and local governments. Government departments also do their own surveys and it is always worthwhile to check what they have available. You may find that the Housing Department has already done a survey of the needs of a particular area - or your local university, or equivalent. Do not be afraid to ask Geography or Sociology departments if they can help.

**Advantages of Quantitative Research**

- Frequently, quantitative research data is representative of large groups and so can be used to derive inferences for whole populations. It is generally regarded therefore with considerable respect by policy designers, for example, and can be used with great effect to influence changes.

- Quantitative data can be used to dispel myths; for example, a population survey may link household sizes with the numbers of working parents - to discount a generally held belief that there is no need for child care.

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**It was generally believed by service providers that a particular ‘disadvantaged’ area in Adelaide would be considered undesirable to live in for both residents and outsiders. However, a survey revealed that residents preferred to live there as many had done so for a long time; they knew the area and many neighbours; and they saw it as having definite advantages, including good access to transport and medical services.**

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- Quantitative data can yield statistical information about populations from which other needs can be inferred.

- Quantitative data can provide sufficient information for testing some hunches of health workers.

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**Community workers interviewed in the Marion, Brighton and Glenelg Community Health Needs Assessment reported a concern that young people in the area were turning away from wine coolers and beer to spirits. This was supported in a survey conducted with young people, who reported that spirits were considerably more popular than beer or wine. Preference for spirits was twice as high amongst young people as any other age group.**
- Quantitative data can assist with broad comparisons between communities - depending on methodological similarities.
- Quantitative data can be used to help assess the extent of demographic change in communities over time.
- Basic data from quantitative research usually can be easily presented and readily understood by many.
- Quantitative data can be readily used to establish arguments for new programs or services which must be developed prior to efforts to solicit funding for particular programs.

Limitations of Quantitative Research

- Even straight forward counting exercises such as the Census, are not without serious problems. For example, the Aboriginal population 'rose' 70% in urban areas between 1981 and 1986 (ABS Publications are available that explore reasons for this).
- In the physical sciences, it is a relatively simple matter to assess the need of a diabetic for insulin and to test the effectiveness of the insulin in controlling the diabetes. Measurement is straight forward and precise. However, community health, as we must emphasise, is applied social science. It is in the realm of culture and interpretation and subjective meaning. For example, it may be considerably more difficult to determine the need of the diabetic for counselling, to assist him or her to manage their medical condition.
- For this reason, the statistical methods of quantitative research are often inappropriate in community health where the information sought is often ambiguous, frequently not quantifiable at all, and where problems are complex.
- Tests of statistical significance form an important part of the type of descriptive statistics that are common in needs assessment. These have a place but there are dangers; for example statistical significance is not the same as social/clinical significance and it does not necessarily represent any causal link in the variables being analysed. They also require certain conditions for their valid use.

While we found in the Marion, Brighton and Glenelg Community Health Needs Assessment that income and health status was linked, we could not assume this was a causal relationship and needed to look beyond the quantitative data to explore this relationship.
If we rely solely on quantifiable data in needs assessments we may overlook genuine needs. The SCHRU reported an example of this, and of bureaucratic blindness, in the Marion, Brighton and Glenelg Community Health Needs Assessment.

Community workers reported that residents of the suburbs east of Lonsdale Road were experiencing considerable stress because the high school and the nearest shopping centre was on the west side of Lonsdale Road, which is a four lane 100kph highway with no traffic lights, no overpass and no underpass. When we contacted the Highways Department, we were told that there was no need for lights or an under- or over-pass because the Highways Department employee had spent a day parked by the side of the road and during that time not one person had attempted to cross Lonsdale Road.

A proper analysis would have allowed several days (randomly chosen) to observe/survey road use and would have incorporated other quantitative research, at the very least. But who in their right mind would cross a four lane highway regularly anyway? Ultimately, other information was utilised and there are now lights enabling residents to cross Lonsdale Road in safety.

Quantitative research may also blur the distinction between the problem and the solution, as when waiting lists for professionals and specific services are taken as an indication of need.

With the population ageing and older people living longer, a survey of hostels revealed many elderly people on waiting lists. An immediate response to this might be to suggest an urgent need to increase the number of hostel places. However, an alternative response may be to increase the funding to home help services to enable at least some to stay in their own homes.

In quantitative research, especially where there is not a trusting relationship between the interviewer and the respondent, it is easier and therefore more likely for respondents to provide socially acceptable rather than accurate answers to sensitive questions.
The Best of All Possible Worlds

No one type of research meets all needs and often a combination of quantitative and qualitative research is the best option. Quantitative methods are often used to depict the broad sociological characteristics of a population together with information concerning the use of various services. These latter data, then, frequently indicate the need for further intensive qualitative research which allows the exploration of such issues in considerable depth. Topics such as these are developed in Section 4.
NEEDS ASSESSMENT OVERVIEW

COMMUNITY INPUT AND DETERMINATION OF PROJECT DIRECTION... CONTINUES THROUGHOUT

STAGES

PLANNING

1. Define population
2. Identify budget
3. Set sample size
4. Decide type of survey
   - Face-to-Face, Telephone, Mail
5. Design questionnaire
6. Select sample
7. Pilot questionnaire & modify
8. Train interviewers & run survey
9. Prepare & process data
10. Analyze results
11. Interpret results

IMPLEMENTATION

ANALYSIS

1. Identify needs
2. Community consultation... feedback
3. Recommendations, action strategies

INTERPRETATION

REPORT PREPARATION

REPORT... ACTION... INFORMATION DISSEMINATION... INCLUDING PRESS RELEASES...
CHAPTER 4 - Examples of Community Needs Assessment in Action

Needs assessments can take many forms, ranging from community health workers listening to a community's problems at a neighbourhood meeting, to a project that makes use of a whole range of techniques and involves a substantial budget.

The Noarlunga and the Marion, Brighton and Glenelg surveys were of this latter kind. A wide range of qualitative and quantitative techniques was used, including a relatively expensive survey. A major impetus for the two studies was to develop a model which could be used whole or in part by community health workers. A less well-resourced project was conducted in a country area - the lower north of South Australia. Throughout this Manual we will be citing examples from these three exercises to illustrate particular points and techniques.

This chapter provides an overview of the Noarlunga, Lower North, and Marion, Brighton and Glenelg Community Health Needs Assessments.

Noarlunga

The Noarlunga project was divided into two distinct phases: problem identification and problem solution.

Problem Identification

The problem identification stage involved a postal survey of a randomly selected group of adult residents of Noarlunga (n = 1495, representing a 74 percent response rate). The questionnaire was designed in collaboration with local workers and a health advisory committee, and included sections on: socio-demographic data, health status, community care, life experiences, use of community health services, and perceptions of the local area. Each person in the sample received two questionnaires. One was for them to complete about themselves and the other was to be completed if they were the parent, step-parent or guardian of a child 18 years or younger. The data were intended to be used by local service providers for planning and establishing areas of service priority and to provide a broader social health perspective on the local community for both service providers and community members.
Problem Solution

Once the survey had been completed and the results analysed, the next stage of the research process involved feedback to the community and defining possible strategies for action. This was achieved in a number of ways.

- Producing an attractive non-technical report outlining the main results of the study. The report, *Noarlunga's Health - Apathy or Action?*, was distributed to respondents in the survey as well as to relevant government and community organisations.
- Media publicity about the results of the survey, in particular highlighting the social and economic factors inherent in ill health.

- The organisation of a Health Issues Day involving the community and relevant health workers. This was to discuss results from the survey and to recommend strategies for action to address health and social issues of concern in Noarlunga. The Health Issues Day was structured around a series of workshops that addressed topics identified by the survey results as important to the Noarlunga community. Approximately 160 people, the majority of whom were community members, attended all or part of this activity.

One of the main outcomes of the Health Issues Day was the dissemination of information. A report of the Health Issues Day was produced and sent to participants, community groups and relevant government departments, highlighting particular recommendations of relevance. There was also a ‘ripple effect’ - the spread of information as a result of people discussing the information and ideas from the Health Issues Day and survey report.

Another outcome was the formation of networks. Health workers and community members joined together to maintain ongoing action to develop health in the community; for example, a youth network and consumer advisory bodies were organised by workers at the Noarlunga Health Village as a result of the Health Issues Day. The Day also led to increased awareness of health issues, and promotion of the idea that health is more than the absence of illness.

Recommendations from the research were picked up by the Healthy Cities Project which was able to take action in many areas identified by the research. The information has proved to be a useful reference point for the development of this innovative health promotion project. For further details contact Trevor Townson, National Co-ordinator, Healthy Cities, (02) 389 1433.

A Needs Assessment in a Country Area: The Lower North of South Australia (region around the Clare Valley)

This needs assessment was conducted in a country region situated to the north of Adelaide. There were not sufficient funds to conduct a random population survey so the study comprised:
- a summary of ABS and other published data;
- a key informant survey;
- public meetings.

The research followed the model used in Noarlunga and Marion, Brighton and Glenelg.

The conduct of the Community Needs Assessment was made difficult by the SA Health Commission’s proposed role redefinition for local hospitals, to which many community members were opposed.

The Marion, Brighton and Glenelg Community Health Needs Assessment

In July 1987 the Research Unit received a grant to develop and test a model of a needs assessment for community health services.

The Local Government Areas (LGAs) of Marion, Brighton and Glenelg were chosen as the area to develop the model because relocations and changes to health services were being considered for that area.

The map on the opposite page, reproduced from the project report, identifies the three Adelaide communities involved.

The aims of the assessment were:

- to develop a model, using rigorous research methodologies, suitable for community health services and incorporating the community health values of equity, illness prevention and community involvement;
- to illustrate and clarify the distinction between problem identification and problem solution;
- to provide information which could be used by Government and non-Government agencies, and community groups, to make Marion, Brighton and Glenelg a healthier place to live.
The Stages of the Marion, Brighton and Glenelg Community Health Needs Assessment

Stage 1  First Steps: Winter 1987

Establishment of a research team and a steering committee for the project.

Discussion with staff of community health services in the area about their involvement in the project.

Drafting a plan, a budget, and a time frame.

Literature review.

Review of earlier research in the area

Review of earlier needs assessments on health and related issues.

Stage 2  Planning: Winter and Spring 1987

Drafting and piloting a survey questionnaire, in consultation with the steering committee, to determine the health status of residents in the area, their use of services and their present satisfaction and dissatisfaction with services.

Two questionnaires were developed - one for all recipients and the other for recipients who were parents or who cared for children under 18 years of age. A copy of these two questionnaires are in Appendix 1.4.

The questionnaires incorporated questions from:

- the Noarlunga Community Health Survey, an earlier survey by the Southern Community Health Research Unit;

- the Nottingham Health Profile - this instrument, developed by the Department of Community Health of the University of Nottingham Medical School in England, was included in its entirety to provide measures on the critical health factors of sleep, energy, emotional reactions, pain, physical mobility and isolation;

- a Study of Health and Diet, a questionnaire developed by the C.S.I.R.O Division of Food Research, Highton, Victoria and the Division of Human Nutrition, Adelaide, South Australia.
A booklet was used to gather community service providers' perceptions of the problems and unmet needs of the community. A copy of this booklet is included in Appendix 1.5.

**Stage 3  Obtaining Information: Spring 1987 to Summer 1988**

The two survey questionnaires, together with a letter and a self-addressed envelope, were sent to a sample of 2500 people randomly selected from the electoral rolls of the three council areas. After 14 days, a reminder card was sent to questionnaire recipients who had not returned their questionnaires, and after a further 14 days a new questionnaire was sent. Overall, 71.7% of respondents returned completed questionnaires.

The booklet for community workers was sent to schools, and to health and other community workers in the area. Personal contact was made with the recipients of the booklet before it was sent.

Health service workers and other professionals in the area (e.g. police) were contacted to obtain their perceptions of the needs of residents and of the community generally.

A meeting was arranged with local general medical practitioners in the area to discuss the types of problems they were seeing in their practices.

Service providers were re-contacted to follow up particular issues that had been raised but not fully documented or explained.

Information obtained from community workers was documented and returned to them and other interested parties for comment.

**Stage 4  Analysing Information and Survey Results: Autumn to Winter 1988**

Contributions from service providers were summarised. Problem identification was separated from problem solution. Values inherent in the reports were identified. Survey results were analysed.

Quantitative and qualitative data were compared, assessed and integrated.

Results were reviewed with service providers and the Steering Committee.

The main subject areas of the Reports were established with the Steering Committee.
Stage 5  Preparing Reports and Returning the Information to the Community: Spring 1988 to Autumn 1989

Four reports - *A Social Health Perspective, The Youth Report, The Older Persons Report,* and *Parents and Children* - were drafted.

The draft reports were distributed to the steering committee and service providers, workshops were then held to discuss the results, and to suggest possible recommendations and ideas for action.

A final report, with recommendations or ideas for action, was published.

Supplementary Information Sheets were produced covering aspects of the research not covered in the four reports, e.g. *Carers, Use of GPs.*

The reports were given a public launch, with an open invitation to members of the community and community workers, and specific invitations to community members who had been involved in the Assessment through the community survey. Success in attracting media attention was an important aspect of these launches.

Press releases obtained considerable media attention. Researchers spoke to community groups, Councils, and service providers on the results of the assessment.

During all stages, there were consultations with the steering committee. Information was fed back to the people from whom it had been obtained for comment, clarification and elaboration, and to ensure a two-way exchange of information.
An Assessment of the Marion Brighton and Glenelg Community Health Needs Assessment

The Questionnaire

Overall we were happy with the questionnaire. As most of the questions had been pre-tested in earlier surveys, there was little possibility of any major failures. We would have no hesitation in repeating the same questionnaire with minor modifications. This is not to say that the questionnaire could not be improved. We doubt there is such an instrument as a perfect questionnaire.

Obtaining Information from Community Workers

Although we were happy with the design of the booklet that asked community workers to summarise the needs they were aware of through their work, the response to it by community workers was not as positive as we had hoped.

It seemed that some community workers felt threatened by the booklet and were not prepared to take the time to fill it in. Despite this, they were prepared to spend long periods talking to researchers about the issues in their areas.

A similar booklet was used in the Lower North Needs Assessment where it proved more successful. As this was a country area, it was not possible for community workers to be individually interviewed and, appreciating this, they were more willing to fill in the booklet and return it to the Research Unit.

The Steering Committee

The composition of the steering committee changed over the two years of the project as representatives from various organisations changed. Altogether, 47 people served on the committee, although the largest number of people to sit at one time was 18.

There were two surveys of committee members to determine how the committee felt about the process of the Needs Assessment, and their involvement. Replies from committee members were anonymous and the following points emerged.

• For the committee members, one of the most positive aspects of the assessment was the opportunity it gave them to establish contacts with other organisations. This networking aspect of the committee was rated extremely highly in both surveys.
Committee members thought the monthly meetings gave them sufficient opportunity to contribute to the assessment, and members generally appreciated this opportunity and felt that they had contributed materially to the project, especially in the drawing up of recommendations. The area in which they felt they had the least input was questionnaire design.

During the project there was some concern expressed by committee members about what would happen to the information that was being collected, and considerable concern that the research would not obtain enough exposure and consequently would not be acted on. By the end of the project this concern had vanished. The final discussion of the steering committee revealed that a number of councils, government and community organisations were addressing specific issues raised in the research. Action on the reports was still being taken at the time of publication of this Manual.

Committee members enjoyed their participation and were extremely positive in their evaluation of the Needs Assessment process and outcome.

The Reports

The non-technical reports proved a highly successful way of transmitting the findings from the survey to a wide audience of professional workers and community groups. The technique of having a public launch of the reports has been an excellent means of giving the reports a high profile in the community and attracting media attention.
SECTION TWO: Before You Start

1. Crucial Issues
2. Research Ethics
3. First Questions
4. First Steps
CHAPTER 1 - Crucial Issues

Relevant literature and our experience suggests that four issues are central to the design and conduct of a needs assessment intended for planning healthy communities:

- defining the difference between a problem and a solution;
- recognising that needs assessment is dependent on values;
- community involvement;
- using a social health framework.

Defining the Difference between a Problem and a Solution

When people, including professional workers, talk about needs assessment, they often go straight to defining a solution, without defining the problem and considering fully a range of solutions. This means that they often offer a solution in terms of what has been done before, rather than thinking more innovatively.

For example:

-'The community needs more counselling services for delinquent young people.' The problem is that young people hang around the shopping centres, graffiti walls, shout comments at passersby and sometimes get drunk. Other solutions might be:
- provide an alternative meeting place;
- provide a youth worker;
- increase local youth employment opportunities.

Another example:

-'The old frail people in our community need more nursing homes.' The problem is that older people who are frail or disabled often don't have access to enough support to enable them to continue to live independently. Other solutions might be:
- better provision of home-based medical and para-medical care services and home maintenance services;
- provision of income-support of community carers of older frail people.
When you are doing a needs assessment, it is crucial that you identify the problem you are trying to solve, and consult a wide range of people about possible solutions. Remember that creativity is important - it may enable you to move away from current practice.

<table>
<thead>
<tr>
<th>Clarify the problem first.</th>
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<tr>
<td>Think creatively and laterally.</td>
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<tr>
<td>Seek ideas from many people before coming up with solutions.</td>
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<tr>
<td>Check out what the strengths of the community are.</td>
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So, planning for healthy communities should be conceptualised in two distinct phases: identifying problems and solving them. Figure 2 outlines these. In practice, of course, the two stages may overlap.

**Needs Assessment is Dependent on Values**

Searching for value-free needs assessment is a bit like the search for the Holy Grail - not very likely to be successful. Value judgements creep into all stages of needs assessment - from deciding what area of need to investigate, to determining what actions should be taken to solve identified problems.

Traditional scientific practice assumes that science should be value-free. In recent decades, this assumption has been queried and there is increasing recognition that much science reflects and incorporates values. This is particularly the case in the social sciences - the tradition from which most needs assessment methodologies come.

The following example demonstrates the role values play in needs assessment.

A multi-disciplinary youth team in a community health centre wants to look at the needs of young people in their district. They debate what topic would be most important to investigate given their limited resources. The psychologist advocates looking at mental health issues, the social worker at homelessness, the nutritionist at diet and the young community representative at recreation needs. You can see how particular professional perspectives come into play here.
The team decides to look at nutritional issues because this fits with the Centre's priorities and is one of the priority areas of investigation identified by the Health For All Committee. The team discovers after some survey research and literature review with young people that those in low income households eat a less nutritionally well-balanced diet than those in higher income households.

The team is divided on what to do about this. The social worker feels the team should devote a proportion of its time to lobbying governments about income support for young people and in encouraging the local council to establish local employment programs. The psychologist believes there should be an education program to teach young people about healthy eating and taking responsibility for one's own health. The nutritionist is keen to establish a healthy youth cafe that would provide modelling in how to prepare healthy and nutritious food. The young community representative isn't sure that what people eat is important because it only has long term effects and most people her age aren't bothered by that.

After much discussion, they realise they have some basic value-differences in how they explain the fact that young people in low-income households eat a less nutritionally well-balanced diet than those in higher-income households. The social workers believe this reflects structural factors that affect the less well-off young people, that their choices are constrained by the supply of food in local supermarkets in poorer areas (e.g. less fresh fruit and vegetables) and the fact that healthier food is more expensive.

The psychologist has a different perspective and believes that anyone can eat a healthy diet if they want to. He believes poor people are more likely to be irresponsible and waste the money they have on grog and cigarettes.

The nutritionists believes that the low-income young people have never had the opportunity to learn to appreciate healthy food because they've been brought up in homes where they have been given junk food much of the time.

The community representative thinks the health professionals are too concerned with the issue of healthy eating and that all their perspectives reflect a professional middle-class model. Most young people, she maintains, are more interested in having a good time than in eating boring healthy food so they will be healthy in 20 years time.
Finally, the team comes to appreciate that these perspectives are based on values - none are right, none are wrong. This recognition helps them considerably in their further planning.

**Don't ignore values. Incorporate them in needs assessment and clarify how people's views differ.**

### Community Involvement

To encourage the participation and involvement of local people in the program, it is necessary to think laterally and challenge current values (Lewin et al 1990).

Anyone who has tried to involve communities knows that behind the rhetoric lie the problems of instituting a process that results in genuine involvement and not just in tokenism. Despite the best intention of professionals, we often end up with tokenism. Yet it is also clear that consulting with community members is essential to most needs assessments if they are to produce useful insights.
Methods of doing this are dealt with later on in this Manual. Here we will specify some general principles:

- take sufficient time - consultation can’t be hurried;
- develop good listening skills - open your ears and be receptive to other peoples’ perspectives even if you don’t agree with them;
- try also to consult those who aren’t vocal - the hidden majority;
- think creatively of ways to consult the community;
- feed back your results to the community - in a report in plain language or through the media;
- tap in to existing community groups.

After the report from the Noarlunga needs assessment was published (Noarlunga’s Health - Apathy or Action?), a Health Issues Day was organised to encourage local people to have their say about solutions to the problems identified.

The Noarlunga Healthy Cities Project ran a series of Vision Workshops to elicit from local people their visions of what an ideally healthy Noarlunga would look like.

Using a Social Health Framework

Connected to the issue of values is the issue of the framework used to plan healthy communities. It is crucial that a project team defines this. The surveys the Southern Community Health Research Unit has done were all based on a social health perspective, which means that the social context of health was recognised. To us it made sense to view community health in this context - it is essentially a public activity that focuses on the population as a whole, not just on the individuals within a community. We found it useful to refer to the Ottawa Charter for Health Promotion (WHO 1986). This Charter proposes five areas in which health promotion activity can happen.

**Healthy Public Policy:** promoting health through policy change.

**Creating Supportive Environments:** to include physical, social and economic environments.

**Strengthening Community Action:** encouraging community involvement in actions to promote health.
Developing Personal Skills: recognising the role of individuals in taking responsibility for their own health but avoiding blaming the victim; concentrating on individual skills for:

- participation in community action;
- mutual support;
- self esteem;
- making healthy lifestyle choices;
- self care.

Reorienting Health Services: ensuring that health services do more preventive work.

This framework is designed to be ecologically sound, by taking into account sustainability and equity.

Clarifying your framework can provide a forum for a discussion of values and approaches, which is important to the success of a project.

In South Australia, the Health Commission has a clear mandate to operate within a social health model:

_A social view of health is one that recognises the impact (both direct and indirect) which physical, socio-economic and cultural aspects of the environment have on the health of the community. A social view of health implies that we must intervene to change those aspects of the environment which are promoting ill health, rather than continue to simply deal with illness after it appears, or continue to exhort individuals to change their attitudes and lifestyles when, in fact, the environment in which they live and work gives them little choice or support for making such changes_ (Cornwall 1988).

This view of health accepts that most activities in our communities ultimately have an impact on our health. This means that appropriate community health needs assessment has to go beyond the documentation of the extent of illness, disability and causes of death in our community, to consider those factors that affect well-being and promote health. It also has to reflect an understanding of social processes and how these contribute to poor health. These complex issues need to be discussed in our community. The following diagram was used in the _Marion, Brighton and Glenelg Social Health Report_ to illustrate some of these relationships.
The Links Between Poverty and Health Status

Low Income down to Poverty

- Lower Level of Formal Education
- Problems Dealing with Health/Welfare Professionals
- Problems Getting Paid Employment
- Less Access to Private Transport

Coping on a Limited Budget
- Less Control and Ability to Plan for Future
- Less Ability to Participate in Activities to Sport
- No $ for Extras, No Savings for Emergencies

- Less Social Contacts
- Stigma
- Stigma Guilt

- Isolation
- Depression

- Children Inadequately Clothed and Fed
- Inadequate Diet Nutritiously

More Reported Illness, Die Earlier
Clearly, this approach is looking beyond the individual and also considering the health of a community as a whole. This means taking a public health approach rather than an individual one.

A holistic approach to needs assessment will make more demands on a research team but will also produce relevant information for planning healthy communities.
**PLANNING FOR HEALTHY COMMUNITIES**

**PART ONE: Identifying the Problem**

<table>
<thead>
<tr>
<th>STAGES OF PROJECT</th>
<th>WHO/WHAT IS INVOLVED?</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of Project Steering Committee and deciding goal and scope of study</td>
<td>Representatives of community groups, service providers, resource allocators, research team</td>
<td>Project team meetings</td>
</tr>
<tr>
<td></td>
<td>Explantion of method; decision on methods (depends also on resources)</td>
<td>Discussions with local agencies and community groups</td>
</tr>
<tr>
<td>Quantification of areas of concern</td>
<td>Design of questionnaire in consultation with project team to gather information on illness experiences, measures of social well-being, perceptions, and attitudes</td>
<td>Questionnaire to random sample of population, or to particular groups of interest</td>
</tr>
<tr>
<td></td>
<td>Collation of existing data (demographic, morbidity, mortality, environmental, etc.)</td>
<td></td>
</tr>
<tr>
<td>Qualitative assessment of areas of concern</td>
<td>Research team, steering committee members, local service providers, community members; production of in-depth exploration of areas of concern concentrating on social processes using a variety of methods: (groups, interviews, observation, etc.)</td>
<td>Visits to all relevant local agencies; consultation with different groups; assessment of existing resources</td>
</tr>
</tbody>
</table>

**ANALYSIS OF ALL DATA GATHERED:**

and, remember to also:
explore the STRENGTHS of the local community
**PLANNING FOR HEALTHY COMMUNITIES**  
**PART TWO: Coming up with 'solutions'**

<table>
<thead>
<tr>
<th>STAGES OF:</th>
<th>WHO/WHAT IS INVOLVED?</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting back research results to all parties and providing them with opportunities for discussion</td>
<td>Researcher's steering committee; relevant Government and non-Government agencies</td>
<td>Concise reports on, for example: Social health Youth Aged Parenting • Information sheets • Workshops • Media • Local networks • Academic publications</td>
</tr>
<tr>
<td>Planning responses to problems, building strengths and establishing priorities</td>
<td>Community groups, bureaucracies, local service providers</td>
<td>Results used over a long period to influence development of services and other initiatives Encourage lateral thinking and new ideas</td>
</tr>
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</table>

**ACTION**
CHAPTER 2 - Research Ethics

Research Priorities

For a decade or more, a burning issue in medical ethics has been the dilemma involved in containing health service expenditure at the cost of equity or quality of care or both. It is certainly time that the ethical issues relating to the allocation of scarce medical research resources were subjected to similar serious study in Australia (Rutnam 1988:127-133).

There is some concern that with new technology, medical researchers are spending valuable resources in areas that are of interest to them but that will not be of benefit to society as a whole, nor to those people whose health is generally poorer than that of the rest of the community.

As workers with limited resources, we have to ask ourselves if the research we are contemplating is within a community health framework.

- Will the research assist in achieving the goal of health equity?
- Does it allow for community participation and involvement?
- Will the results of the research be used?

If the answer is “no” we have to question the value of the research.

Who Owns the Information?

When researchers use communities for their own and not the community’s benefit, research is in danger of obtaining a poor reputation.

We found this when we approached the schools in Marion, Brighton and Glenelg, asking them to provide information on the needs of the young people in the area. A common response from the schools was,

‘Oh no, not again.’
The schools were sick and tired of providing information to researchers when there was no benefit to the schools. Both Flinders University and the Sturt campus of the South Australian College of Advanced Education are in Marion and the schools have been seen as fertile grounds for students doing research. The research disrupted classes and took the time of the teachers and the students. Very rarely did the school hear anything about the results of the research.

Information collected during research belongs not only to the researchers but also to the community or population from which the information has been taken.

At the Southern Community Health Research Unit, at the end of each research project, we allocate time and resources to reporting our results to the community.

The reports of the Marion, Brighton and Glenelg Community Health Needs Assessment were given public launches. Special individual invitations to the launch were sent to randomly selected respondents who had replied to the Community Survey. Displays were set up at shopping centres and in libraries to further inform the community of the findings of the research.

When information is collected from a community, then that community should benefit from it. When research is done for an academic degree or part of course work, this is even more important.
Informed Consent

It is important that, before people give their consent to take part in a study, they are fully informed about the research project and their role in it. Potential participants should receive both a verbal explanation of the aims and procedures of the research and of the nature and extent of their involvement, as well as a formal written statement, a copy of which they retain. The formal statement ensures that everyone receives the correct information and that this information is the same for all participants. This provides a permanent statement that the participants can refer to, and it offers protection for the research team should there be any questions about the participants’ involvement in the research at a later date.

Because community health workers’ clients feel obligated to those who have helped them, they may agree to take part in a research project when they would actually prefer not to. For this reason it is preferable to have someone not known to these people ask for their participation in a study. In this way the client is not constrained by a sense of obligation, and is free to make up his or her own mind.

Similarly, care must be taken to reassure clients that their agreement or refusal will in no way affect their relationship with the Centre or the services they are receiving. It is also important to stress to potential participants that they can pull out of a study at any time.

There are special problems when children or members of special groups (e.g. people with poor English) are involved in a research project. In the former, it is important to ensure that both the child and the parents are fully informed and have agreed to the child’s participation; in the latter it is important to determine that the participant in the survey is fully aware of what he or she has been asked to do and is not participating because of a decision by another family member or community leader.

Access to User Records

Sometimes there is the temptation to obtain access to a particular population through client records. For instance, workers at a community health centre may decide they need more information about people with high cholesterol levels. One way to find such a population may be to go back through the client records to obtain a list of people with high cholesterol.
This is an invasion of privacy and not a legitimate use of client records. If clients are to be included in a research project, they must be asked during their normal consultation if they would agree to be part of the research. Written approval must be given before client records can be examined as part of a research project. Clients should not, of course, be identifiable and only aggregate data should be presented in a report.

Before health workers or anyone else in South Australia uses client records for gathering information, permission must be obtained from the Privacy Committee of South Australia. This Committee was set up to ensure that there are no intrusions of privacy where government records are concerned. In South Australia, this Committee comes under the Attorney General’s Department. Community health workers from other States must check whether there is similar legislation in their own State.

The Right to Privacy

The question of privacy arises both in quantitative and qualitative research. Survey questionnaires are usually numbered or otherwise identified so that people who have not returned questionnaires can be followed up with a reminder. When there is an identification code it is possible for the researcher to identity a particular questionnaire as belonging to a particular person. However, it is a fundamental requirement that the information supplied by survey respondents is entirely anonymous and will not be traced back to them. It is the responsibility of the researcher to ensure that this is the case.

There is also the assumption implicit in survey research that the individual information supplied by survey respondents will be used only for the purpose stated and that it will not be made available to any other person or organisation.

Sometimes a person who is sent a mail interview, or who is telephoned, will want to know why they were approached. It is important at the outset of a study that the people included in a sample are informed of how their names were obtained and the basis on which they were selected for inclusion in the sample.

In qualitative research, the danger is that a particular person cited in an example may be identified by someone reading the report. This danger is overcome by changing the details of the example so that there is no way that a particular person or family could be identified.
Submitting Your Research Design to an Ethics Committee

Research studies in universities and hospitals have to obtain the approval of an ethics committee before they start.

Ethics committees for community health research have not yet been established. There is a move in South Australia, however, to establish a set of guidelines for community health research and a system for monitoring the ethical standards of research. The system proposed is that in most cases ethical issues would be dealt with at a local level. Researchers wishing to seek ethical approval for the purposes of applying for research funding (a requirement of most funding bodies) would use a State-wide community health research ethics committee.

This committee would also be responsible for instituting a training program for people at a local level. This proposal has been developed by a committee comprising representatives from research units, community health centres and the SA Health
Commission. Details of its progress can be obtained from the SCHRU.

As researchers have a strong commitment to their research, they can easily overlook the ethical implications of what they are about to do. This is why it is important to have access to a committee which is not associated with the research and which can scrutinise objectively the research plan to ensure that it does not involve an invasion of privacy, use of privileged information, or some other infringement of community or individual rights.

As well as looking at the above factors, the ethics committee must be satisfied that:

- the research is likely to acquire knowledge that may improve the health of the community;
- the investigators have the necessary skills and resources to carry out the research;
- the methodology proposed is appropriate.

To help the ethics committee examine your research design, it is necessary to submit in writing a statement of the aims of the study, the data that is needed, and the way the data will be collected, used and protected.

**Reporting Research Results**

In research reporting, there is a tendency to focus on negative results. Positive results should be given equal prominence. This is especially important if the research project focuses on a specific group or geographic area. Solely negative results can stigmatise a whole community and in this way add to already existing problems.

**Acknowledging Help**

At the end of a project, it is easy to overlook those people who helped you during the research. It is a good idea to keep a list of the people you talk to as you go along, so that in the final report you can acknowledge everyone who contributed to the project.
CHAPTER 3 - First Questions

What is the Purpose of the Research?

If we could set up an overall rule for research, it would be to know exactly what you want before you start.

Planning a research project is a little like planning an excursion with a number of people. It works better if before you set out you obtain agreement on where you want to go and why, how you plan to get there, and if you have enough time and money to complete the journey.

Before any decisions are made, it is essential that team members get together to reach agreement on the aims and goals of the research. This is the time for everyone to reveal their own agendas and to clarify their assumptions. Problems can develop, and team members can start pulling in different directions, if researchers are not clear about all aspects of the research right from the beginning.

To avoid problems later on, before starting on a needs assessment, the research team should consider and answer the following questions.
What exactly do we want to know?
Why do we want to know it?
What will be done with the information when we get it?

**What Exactly Do We Want to Know?**

In 1988 the Research Unit was asked to provide advice to community health and welfare workers on a needs assessment. Workers from three different areas were involved and it soon became clear that the group had never actually agreed on the specific aims of the needs assessment. Each worker had their own agenda which they tried to incorporate into the research design. The consequent confusion threatened the whole project.

It is rare that the aims of the needs assessment will be as wide as they were in the youth section of the Marion, Brighton and Glenelg Community Health Needs Assessment:

To discover the health needs and problems of young people in Marion, Brighton and Glenelg and how they are being met.

More likely the types of questions asked by a community health centre would be:

Are there any groups in the local community whose health is suffering because they have needs that are not being met?

What are the health needs of middle aged women in this area that are not being met?
Is isolation a problem for elderly men in this community? And if it is, what (if anything) can be done to solve the problem?

Clear and unequivocal questions like these should form the basis of all needs assessments, because they answer the fundamental question ‘what exactly do we want to know’?

Why do we Want to Know It?

As well as answering ‘what’, it is also necessary to answer ‘why’.
In Chapter 2 of Section 1, we stressed the importance of examining motives to ensure that the research is not done for the wrong reason and that, at the completion of the research, there is the possibility of change based on the results.

What Will be Done With the Results?

There is not much point finding out that middle aged women need podiatry services if there is no possibility of providing those resources.

This doesn’t mean that the community health centre has to have the resources to take action on the findings of the research, but some possibility of action must exist even if it is only to use the information from the research to lobby funding bodies for the necessary resources.

What is the Direction of the Research?

Once ‘what’ and ‘why’ have been settled, the task of the research team is to determine the direction of the research. The following six questions provide a framework for setting this direction.

1. What information is already available?

2. What additional information do we need?

3. How is the information best acquired?

4. What valid information can be obtained within the budget?

5. What are the individual responsibilities of team members?

6. How can a community health perspective be ensured?
What Information Is Already Available?

Check with local libraries, local health departments and local councils. Talk to people who know the topic area (e.g. youth workers) and people who know the geographical area (e.g. council workers).

After finding out what information is already available, you may discover that part or all of the study you are contemplating has already been done. The role of your research may then be to supplement previous research, or to answer some of the questions raised by earlier research.

In the Marion, Brighton and Glenelg Community Health Needs Assessment, we were able to build on the findings of the Marion Youth Project, in which youth workers had talked to young people about their needs in a drop-in bus in the Westfield Marion Shopping Centre.

What Additional Information Do We Need?

After identifying what information is already available, the health worker has to determine what other information is needed to satisfy the objectives of the needs assessment.

Although the Marion Youth Project had provided information on the needs of young people who ‘hung around’ a local shopping centre, there was little information on the needs of other young people in the area.

To widen our information base, we requested the co-operation of schools, and from some of the schools in the area obtained feedback on the needs of young people, both from the teachers and from the students themselves.

How Is the Information Best Acquired?

This question can be answered on the basis of what the team knows about quantitative and qualitative research methods. Information on methodology is contained in Sections 3 and 4.
The research techniques should be selected with the following rules in mind.

- The techniques used must suit the objectives of the needs assessment (for instance, if one of the objectives is to find out the incidence of arthritis in a geographical area, qualitative research would be of little use - a survey of residents would be more appropriate).
- The method selected must suit the resources that are available. Surveys are expensive and there is no point planning a survey of a large area with limited funding.
- Information acquired in two different ways (or from two different sources) is more reliable than information provided by one method, or from one source only. Ideally quantitative information should back up qualitative information. As this is not always possible, it is worthwhile using more than one method to obtain information, and where this is not possible, to use a number of different sources.
- Keep an open mind and do not restrict your research to one method because it is the method with which you are most familiar.

In the Marion, Brighton and Glenelg Community Health Needs Assessment, a church worker in the area reported that she had talked to mothers who were being beaten up by their children. As this was the only report we had received on this, we returned to other workers in the area to see if they were aware of mother beating. Other community workers confirmed that they too had heard of instances of mother beating and were concerned about it. In writing up our report, we drew together information on this problem from several diverse sources.
What Valid Information Can Be Obtained within the Budget?

Research need not be expensive to be useful. Each year community health workers do needs assessments as an on-going part of their work without calling them needs assessments, and often without any extra funding.

When workers at Clovelly Park Community Health Centre wanted to become more relevant to the local community, they decided on a program of doorknocking to determine the needs of the local area.

Over several months, workers took time off their normal duties to doorknock the houses in the area asking residents about how the community health centre could help them and what additional services they personally would like to see in the neighbourhood. From these contacts small-scale neighbourhood meetings were set up.

Two needs that were soon identified were:

(i) transport for elderly people to Cooinda (a meeting place for elderly residents), and

(ii) more activities and social contact for middle-aged women.

In response to these two needs, a community bus was provided by the council, and a neighbourhood women’s group was established with the help of workers from the Centre.

Money can be a problem, especially when the aims of the needs assessment are ambitious.

If the type of project that will fit into the funding will not give satisfactory answers to the questions you want to ask, consider abandoning the project.

Research that fails to come up with the answer because the design was inadequate is worse than useless. It harms the reputation of those involved in the research, it makes it difficult for community workers to obtain research grants in the future, and it undermines the faith of bureaucracies and of the community in research.

If resources do not match the plans for the project, it may be necessary to modify your aims and focus on a more specific area.
What Are the Individual Responsibilities of Team Members?

When the budget for a project is small, team members may become questionnaire designers, sample selectors, interviewers and data analysts. It is essential that team members know beforehand what their responsibilities and work load are likely to be. Otherwise the project is in danger of floundering if members find that the demands made upon their time and resources are beyond what they can meet.

How Can a Community Health Perspective Be Ensured?

The previous questions are ones that have to be asked before any piece of research. In community health research there are additional considerations.

- How does the research fit into the framework of community health?
- How will the community be involved in the research?
- What are the values underlying the research?

These questions should be answered in conjunction with Chapter 1 of this Section on Crucial Issues.
CHAPTER 4 - First Steps

Because no two needs assessments are the same, there is no sequence of steps that, if followed, will guarantee a successful needs assessment. What is important is that, at the end of the planning period, all the steps have been completed.

Establish a Budget

Money is a major determinant of what can and what cannot be done.

Very rarely is there enough money to do exactly the kind of needs assessment we feel should be done. More often than not there is a compromise between what is desirable and what is affordable. It is important that, at the beginning of the needs assessment, the available funding be looked at to determine if the information that can be obtained within the budget is worth having.
Don’t forget to include the apparently small items in the budget, such as stationery and postage. By the end of the project, the accumulation of these small items can add up to the cost of one large item.

Here is a list of the items you might need to include in your budget.

Salaries

a) Research/Project Staff

It is important to consider whether or not you need to employ staff that will work with you on the development and implementation of the needs assessment. Research/Project staff in the SA State Public Service are usually employed within the clerical range CO4/CO5. These classifications of course vary from State to State. The National Health and Medical Research Council (NH&MRC) have their own salary levels based on the qualifications of the person you wish to employ. Lists of these salary levels can be obtained from the NH&MRC on request.

b) Clerical Staff

Consider whether it is necessary to employ people to support the work you are doing, e.g. word processing and other clerical tasks.

c) Interviewing Staff

Depending on the nature of the needs assessment exercise, you may need to consider employing people experienced in interviewing. Interviewing staff are usually paid on a casual, hourly basis.

d) Coding and Data Entry Staff

The decision of whether or not to employ staff for coding information or data that has been collected, and to enter this onto a computer, will depend on the size of the needs assessment exercise you are planning. With small projects you could do this work yourself, or ask existing clerical staff.

e) Other Staff

Consider the costs of specialist consultants, e.g. for statistical analysis, or people with particular skills in group work.
Goods and Services

a) **Travel**

These costs may be based, for example, on the use of interviewers’ private vehicles to get to the homes of interviewees.

b) **Computing**

Unless you have access to a computing facility, it will be necessary to consider the costs involved in buying time on a computer to do analysis.

c) **Printing**

Reports and questionnaires will need printing: if there are many, then you’ll need to get a quote from a printer; if there are only a few, calculate the costs of using a photocopier.

d) **Postage**

This is particularly important if you intend conducting a postal survey - and if you are, don’t forget to add in the costs of reminder letters.

e) **Telephone**

This is particularly important if you are conducting a telephone survey.

f) **Stationery**

**Establish a Research Team**

Needs assessments require a time commitment. When health workers undertake a needs assessment without taking on additional staff, it is important to determine that the current staff will have the time to do the needs assessment as well as their regular duties.

A first step then is to determine what staff are available, for how many hours a week, and for what time period.

The second step is to determine who is responsible for the various tasks in the needs assessment.
Set Up a Steering Committee

A well-constituted steering committee is one of the most valuable assets of needs assessment. Properly constituted, the steering committee will:

- provide outside expertise about the matter under investigation, e.g. youth drinking;
- act as a review body making sure that the needs assessment is keeping to its objectives and keeping within its time frame;
- be a source of information, and when the steering committee members do not possess information themselves, they can often direct the research team to where the necessary information can be obtained;
- provide contact between the community and the research team to enable community participation and a two-way flow of information;
- assist in formulating recommendations and ideas for action, and in having these recommendations accepted by the community and by organisations within the community;
- help to publicise the findings of the needs assessment by reporting results to organisations and groups of which they are members.

Composition and Size of the Steering Committee

The composition and size of the steering committee will depend on the size and nature of the needs assessment.

Members of a steering committee should be selected from three categories:

- community health professionals who work in the locality that is being investigated;
- representatives from organisations who are in a position to implement the recommendations, or to agitate for their implementation;
- community representatives from the group or groups whose needs are being investigated.

Steering committees need to be of a size to facilitate decision-making. Twelve is usually regarded as a workable number for a group. However, for a small needs assessment, twelve would be out of proportion to the task at hand. Because of the wide scope of its
investigation, the Marion, Brighton and Glenelg Community Health Needs Assessment had an official steering committee of 24.

What Does the Steering Committee Get Out of It?

Steering committees are not a source of free labour and they will resent it if this is how they are used.

The role of the steering committee is to oversee the project. While you can reasonably expect steering committee members to comment on details of the project, for instance the questionnaire, it would not be reasonable to give them the responsibility for formulating the questionnaire (unless there had been a previous agreement).

Regular meetings of a steering committee can provide an all-too-rare opportunity for networking (contacts between workers from separate organisations working in similar areas) as in the example below.

Networking amongst steering committee members was facilitated early on in the Marion, Brighton and Glenelg Community Health Needs Assessment by combining a workshop and a lunch to encourage committee members to learn about each other and to discover common areas of interest.

In the box on the following page is a list of the organisations that were represented on the Marion, Brighton and Glenelg Community Health Needs Assessment. As the project went for almost two years, there was some change as members moved out of the geographical area or were transferred to other responsibilities within their own organisations. In two cases, original members
resigned from the committee following posting to other areas, returning later following a further reposting.

**LIST OF ORGANISATIONS THAT WERE REPRESENTED ON THE STEERING COMMITTEE OF THE MARION, BRIGHTON & GLENELG COMMUNITY HEALTH NEEDS ASSESSMENT**

Brighton City Council

Marion City Council

Intellectually Disabled Services Council

Southern Child and Adolescent Mental Health Services

Family Planning Association

Family Day Care

Member for Morphett

Member for Brighton

Member for Hayward

Southern Regional Geriatric & Rehabilitation Advisory Committee

M B & G Health & Social Welfare Council

Clovelly Park Uniting Church Community Care

Southern Domiciliary Care & Rehabilitation Centre

Clovelly Park Community Health Centre

Southern Community Health Research Unit

SA Housing Trust

Marion Community Forum

S A Health Commission

Child and Adolescent Family Health Services

Department of Community Welfare (Marion)
Draw Up a Research Plan and a Time Frame

To draw up a research plan you will need to be aware of what resources are available to you. A wide range of research techniques are described in the following chapters.

A time frame for your plan will allow you to plan ahead for when staff are away or when there is a change of staff; it will let your steering committee know the length of their time commitment; and it will determine the way resources are used, for instance if there is funding for a part- or full-time person, the research needs to be organised so that it is completed, or completed to a certain stage, by the time the funding for that person runs out.

<table>
<thead>
<tr>
<th>Marion, Brighton and Glenelg Community Health Needs Assessment</th>
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<tr>
<td>Time-scale</td>
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<tr>
<td><strong>September - October 1987</strong></td>
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<td>Questionnaire Design</td>
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<td>Sampling</td>
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<tr>
<td>Printing of Questionnaire</td>
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<td>Start Qualitative Data Collection</td>
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<td><strong>November 1987 - January 1988</strong></td>
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<td>Mail out and follow up of survey</td>
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<tr>
<td>Analysis and Write up of Data (Qualitative and Quantitative)</td>
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<td>Plus Consult with Steering Committee about Comments</td>
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<td><strong>Preparation and Printing of Report</strong></td>
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<td>Social Health - January 1989</td>
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<td>Publicity in the Community: Libraries, Media, Community Centres</td>
</tr>
<tr>
<td>Health and other Services Incorporate Material into their Planning</td>
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</tbody>
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Review of Literature and Other Resources

The size of your literature and resource review depends on the nature of your needs assessment, its scope, and the work that has already been done in the area of investigation.

The purpose of the literature and resource review is:

- to increase the researcher’s knowledge of the topic;
- to acquaint the researcher with results and materials which can be built on by the proposed research;
- to acquaint the researcher with techniques that have been used already in similar investigations;
- to avoid needless repetition;
- to place the results of the needs assessment in the context of other studies;
- to provide support for the results of your needs assessment, or perhaps to provide a contrary view.

Research is rarely performed in a vacuum. Readers of the results of your needs assessment will want to know how the results of this needs assessment relate to other research results. Even though earlier studies may have been performed in a different geographical area, or the focus of the research may have been slightly different, it is important to report these earlier results. It is possible (but unlikely) that nothing has been done on your particular topic before. The readers of your report should know this.

In the Marion, Brighton and Glenelg Community Health Needs Assessment we looked at residents’ smoking habits. Of particular interest for the Youth Report was the smoking habits of young men and women. Our findings were reported in the context of other studies conducted by the Australian Bureau of Statistics and the South Australia Drug and Alcohol Services Council. We found that cigarette smoking was slightly lower in Marion, Brighton and Glenelg than for South Australia as a whole. And, although other studies had shown the percentage of young girls smoking was increasing, the Marion, Brighton and Glenelg Community Health Needs Assessment was the first study in which the percentage of young girls smoking was higher than the percentage smoking in all other groups of either sex.
surveys
and
questionnaires

Section Three
SECTION THREE: Surveys and Questionnaires

1. Introduction to Sample Surveys
2. Face-to-Face Interviews
3. Telephone Surveys
4. Mail Surveys
5. Introduction to Questionnaires
6. Types of Questions
7. Writing the Question
8. Putting the Questionnaire Together
9. Samples
10. Sample Size
11. From Questionnaire to Analysis
Some Definitions to Help You Use This Section

A POPULATION:
all the people in which you are interested e.g. the total number of people in Australia, the number of people in a neighbourhood, the number of arthritis sufferers in a particular area.

A SAMPLE:
a selection of people from a population.
A RANDOM SAMPLE:
People selected from a population in such a way that everyone in the population has an equal chance of being included in the sample.

A SURVEY:
the gathering and analysis of information about a topic, an area, or a group of people.

A COMMUNITY SURVEY:
a survey of people using a questionnaire or other recognised technique to obtain information about a specific community.
A PILOT SURVEY:
a test run of the community survey instrument (e.g. questionnaire) to see how well it works, to iron out the flaws, and to obtain additional information (e.g. response rate).

RESPONSE RATE:
the number of people who agree to respond to your survey expressed as a percent of the number of people who were approached.
CHAPTER 1 - Introduction to Sample Surveys

This Section provides a comprehensive guide to conducting face-to-face, telephone and mail sample surveys. Our experience suggests that these types of surveys are best used to collect factual or attitudinal information that is relatively straightforward. In general, such methods are more useful for discovering the extent of a phenomenon (such as an opinion, behaviour or illness) rather than for exploring why the phenomenon exists. ‘Why’ explanations are best provided by the qualitative techniques described in Section 4.

Surveys

Survey: a comprehensive study (Collins Australian Pocket English Dictionary)

Surveys are primarily used to study the prevalence of a particular problem, disease, characteristic or attitude.

Asking a class of twelve-year-olds if they liked a movie is a survey. So is a 30-page questionnaire presented to 4000 people randomly selected from a population of millions. Surveys do not have to involve questionnaires or even people. For instance, surveys can be made of vacant beds in a hospital.

Although finding information through qualitative methods can be a survey, the word ‘survey’ is commonly used to describe the process whereby information is collected from a section of a population by means of a structured or semi-structured questionnaire. The information obtained from the questionnaires is then subjected to quantitative analysis, i.e. the results are reported in terms of numbers and percentages:

Twenty two percent of residents over 55 years of age in the Treeville area said they were dissatisfied with public transport.

The Australian Bureau of Statistics refers to this type of survey as a ‘sample survey’ and we will be following this convention (see ABS 1989).
Sample Surveys

Sample surveys are now commonplace in western countries. Market research companies survey us about everything from the brand of cheese we last bought to the political party we prefer. Sample surveys also are used to find out about such matters as the blood pressure range of school children, the nutritional intake of Aborigines and the health needs of communities.

Some surveys take samples from the general population while others look at specific populations, for instance arthritis sufferers, parents of disabled children, or residents of a particular street.

Samples

Very rarely are entire populations surveyed. The Census is one instance of an entire population being surveyed; however, there are other situations where the population is relatively small, for instance the population of people with diabetes in a small city.

When populations are large, surveying the whole population is expensive and unnecessary. A sample taken from that population can tell us about that population as long as a few basic rules are followed. These rules - and the types of things that can go wrong - will be discussed in later chapters.
Questionnaires

Sample surveys collect information by means of questionnaires. Questionnaires can be administered by an interviewer face-to-face or over a telephone, or they can be sent through the mail to be completed - self-administered - by the respondent. These three different methods of collecting information, and a guide to questionnaire design, are provided in the following chapters.

Pilot Surveys

Questionnaire and survey design are tested through the pilot survey. Pilot surveys are essential to ensure that:

- there are no flaws in your survey plan;
- the questionnaire obtains the information that you are seeking; and
- the information you have obtained can be analysed.

Even if there are no major changes to be made to your survey following the pilot study, generally there will be some comment that helps you fine-tune the questionnaire, for example, changing the wording on some questions, adding or clarifying terms. In the box on page 91, there is an example of how piloting can make small but important changes to a questionnaire.
Analysis

It is easy to get carried away with the setting up of a survey, sample selection and questionnaire design, and forget that the information that is collected has to be analysed.

Analysis is not something you can do in a couple of hours when the questionnaires are all in. As you work on the design of the questionnaire, it is important to consider how you will analyse the information.

Analysis can be done by hand and, if you are not familiar with computers and have only a small sample, this can be a satisfactory way to do it. However, hand sorting is time-consuming, and if you need the information sorted into sub-groups, e.g. sex and age, it is cumbersome and prone to error.

Analysing the data with the help of a computer is not difficult but you will need a program to sort the data, and you will need someone who is familiar with the program.

Analysis using computers involves three separate steps.

- First there is the coding, whereby the answers to the questions are transformed or coded into numbers based on instructions on a coding frame.

- When this is complete, the second step is to transfer these codes to the computer. This is the data base.

- The third step is to use the computer program to sort the data and perform the operations needed to get usable information.

In Chapter 11, we provide some guiding principles for translating the information you have gathered from a questionnaire into a form that can be entered onto a computer for analysis.

Reporting Back

Although you may want the results of your survey for internal use, e.g. priority setting, it is also important that the information you obtained from the community is given back to them. Reporting back is covered in Section 5 Chapter 1.
Is a Sample Survey the Right Way to Find Out What You Want to Know?

To answer this question, consider the following points.

- At the beginning, look at your area of interest and decide if it is a suitable topic for a sample survey. It might be that the information you require can be gathered more effectively using qualitative techniques.

- While sample surveys give an understanding of the extent of a problem, or the number of people with a particular point of view, they do not increase our understanding of community processes, nor do they identify the underlying causes of problems. For this reason, they are best used along with the results of qualitative research.

- Sample surveys can be intrusive or they can be impersonal, depending on the type of information being sought, the way the questions are phrased and the method (face-to-face, mail or telephone) being used.

- Because the information that is sought has to be quantified, sample surveys require specific, clearly-worded questions.

- Taking part in a survey can be a frustrating experience for the respondent, especially when the choice of answers is restricted.

Remember, people cannot provide answers to questions that are not asked.

In the Marion, Brighton and Glenelg Community Health Needs Assessment, we included a section for carers. In our original draft of the questionnaire, we asked carers if caring was causing them:

- to restrict their activities;
- financial hardship;
- physical illness;
- stress.

When we piloted the questionnaire, a community worker pointed out that our list was entirely negative. In the final questionnaire we also asked carers if caring was giving them a good deal of satisfaction.

In the survey, more carers said "yes" to satisfaction than said "yes" to any of the other aspects of caring.

If this last aspect of caring had been omitted as in the first draft, we would have received a totally different picture of caring.
When you need to know facts about a population in terms of numbers and percentages that are not available from any existing source, a survey is often the only way of obtaining the information. On the following pages are a chart which will help you decide if a sample survey is really what you need.

The following chapters on survey types, questionnaire design and sampling will guide your work if you have decided that you are going to conduct a survey.

REMEMBER: Sample surveys involving more than 100 people are best suited to collecting factual or uncomplicated attitudinal data. If you want to collect detailed information on attitudes, values and beliefs, qualitative approaches are likely to be more rewarding.
So you think you want to do a

SAMPLE SURVEY

Some guidelines for consideration

START HERE \rightarrow ESTABLISH A STEERING COMMITTEE

Then answer the following questions:

What do you want to know? How much of this information is already available?

What information does YOUR research have to provide?

Do you still consider you need to embark upon a community survey?

Is your target population accessible through a survey?

Yes \rightarrow

Is the data capable of being appropriately quantified, i.e. expressed numerically?

Yes \rightarrow

Is there time to organise a survey taking into account time for analysis, etc?

No \rightarrow

Examining other ways of researching your target population . . . (see Section 4 of this Manual)

Qualitative research methods may provide a more realistic and appropriate alternative.

Cont. over
Continue answering these questions:

**Is the information sought likely to be too sensitive for a sample survey?**
- **Yes**
  - You may need to investigate qualitative research methods.

- **No**
  - Are appropriately trained interviewers available?
  - **Yes**
    - Perhaps a combination of quantitative and qualitative approaches will be appropriate.
    - (Some quantification may be possible without resorting to survey methods)
  - **No**

**Will a sample survey provide the depth and range of information you need, especially on those matters most critical to the investigation?**
- **Yes**

**How is data to be presented? Is quantitative information required (i.e. frequencies and percentages)?**
- **No**

**Do you have sufficient $$$ for a survey and subsequent data entry and analysis?**
- **Yes**

**IF YOU HAVE DECIDED TO CONDUCT A SAMPLE SURVEY . . . see over**
So, you've finally decided to do a

**SAMPLE SURVEY** . . .

Now you need to decide what method to use: some guidelines

- Face-to-face interviews?
- Telephone interviews
- Mail questionnaires

Is there something about your population that suggests one method would be more suitable than the other?

$$$$$$$$
Will any method cost substantially more or less than the others?

Can sufficient interviewing time be afforded?

What about training of interviewers, either for direct interviewing or for telephone interviewing?

Will a telephone survey exclude people you want to reach?

Can questionnaires be made simple, direct, and self-explanatory for a mail questionnaire?

Decide: Face-to-Face, Telephone, or Mail
What next?

SURVEY DESIGN

Some Sample considerations

Where select from?
Telephone book?
(Excludes many without telephones, e.g. many single parents and/or Aboriginal households)

Electoral role?
(Only those 18 years and older. No new residents, no non-Australian citizens)

Door-knock houses
(Have to return when no-one home . . .)

How select?
* Random sample
* Stratified sample
* Cluster sample
* Proportional sample

Some Questionnaire & Interview Schedule considerations

Determine (in writing) the overall objective

Determine each specific objective

Match each objective to variables needed to explore it

Match each variable to questions needed to create that variable

Ensure questions are designed to provide readily analysable data that meets specific objectives; but do not be afraid to include open-ended questions exploring important or difficult matters

Avoid...
Irrelevant, double-barrelled, ambiguous or leading questions

Test questions on friends and co-workers
then
Pilot test . . .

Finalise sample . . . finalise questionnaire . . . print . . . address envelopes (if mail questionnaire) . . . select (and train if necessary) interviewers . . .

Begin fieldwork.
And, remember, there is no perfect question, and no perfect questionnaire

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CHAPTER 2 - Face-to-Face Interviews

Face-to-face interviews conducted as part of a sample survey are usually aimed at collecting quantitative data. Methods for collecting in-depth information are described in Section 4 of this Manual.

Face-to-Face Interviewing Techniques

To obtain valid research information, it is not necessary to adopt a cool neutrality. Good rapport is just as important in obtaining information from face-to-face interviews as it is in counselling. However, in the process of gathering information, the interviewer must try not to influence the content of respondents’ answers.

The tone of voice used in asking a question can influence the answer as much as the wording of a question. Few people want to offend, and if they pick up from vocal cues some indication of how the interviewer wants, or expects, the question to be answered, respondents can unconsciously comply.

Interviewers can fall into developing expectations about certain questions, especially if most previous respondents have answered a particular question in the same way. The interviewer has to guard against building up expectations and against indicating expectations to respondents. Interviewers must endeavour not to send such messages through voice inflexion, facial expression, body posture or movement.

In face-to-face interviews, the interviewer’s appearance can influence respondents’ replies. For instance, if the interviewer is dressed very poorly, respondents may (even unconsciously) underestimate their own income. Conversely, if the interviewer is expensively dressed, respondents may overestimate their income.

What sort of things can affect a face-to-face interview?

- Tone of voice and voice inflexion.
- Eye contact and facial expressions.
- Clothes and accessories.
- Hair style.
- Body movement and ‘body language’.
Advantages and Disadvantages of Face-to-Face Interviewing

The major advantage of face-to-face interviews is that interviewers can establish rapport with respondents and assist them to complete the questionnaire accurately.

On the other hand, face-to-face interviews can be costly and time consuming. Frequently, the interviewer has to travel to the area where the interviews are to take place and may have to cover considerable distances between randomly-selected houses.

When the research design specifies that there can be no replacement of randomly-selected respondents, researchers may have to go back to a particular house several times before securing an interview.
Obtaining Interviews

There are four main ways of obtaining face-to-face interviews:

- knocking on doors;
- approaching people on the street;
- phoning beforehand and booking interviews;
- through captive populations, e.g. schools.

Knocking on Doors

After having rung the bell or knocked, stand back from the door to avoid appearing threatening. Wear clear identification and smile at the person who answers the door.

You should immediately introduce yourself by name and show official identification connecting you with the health centre or the organisation for which you are doing the interviewing.

'Hello. My name is Sue Evans. I am part of a team researching the health of residents in this area for the Treeville Community Health Centre. My colleagues are across the road (down the street). I would like to ask you (or, a member of your household) a few questions about your health and the services you use. Your answers can help us to identify services this community may need.'

Your survey design may specify that you ask the person who answers the door to complete your questionnaire, or it may require that you ask for a particular person, e.g. a young male.

'For this survey I need to talk to a man between 18 and 30 years of age. Is there such a person in your household who is at home at present? Could I speak to him please?'

If the person you have asked for is not the person who answered the door, re-introduce yourself and commence the interview. If the person who answered the door meets the requirements of a respondent for that household, commence the interview.

If the questionnaire is short and simple without answer cards to show (see Chapter 8: Putting the Questionnaire Together), then the interview can be conducted on the doorstep. For more complicated and longer interviews, it is necessary to find a place where the respondent will be at ease.
‘Is there somewhere we can sit down?’

Beware Danger!

In entering a stranger’s house you (or your interviewers) are at risk. You will notice that in the example we gave above, the interviewer made mention of her colleagues. This should not be window-dressing. If you are going into someone’s house, your colleagues should know and the people in the house should know that others know where you are.

Having said this, it is probably worthwhile to note that the Australian Bureau of Statistics has not had one incident where its interviewers have felt that they were at risk.

Also note that it is not only interviewers who can feel threatened; it is possible for aggressive interviewers to frighten and intimidate householders.

Don’t interview at night without an appointment, for your own sake as well as the householder’s.

Another danger is dogs. Don’t enter houses where there is a sign saying Beware of Dog. They may be bluffing, but more often than not they mean it.
Approaching People on the Street

Strictly speaking, for street interviewing you should have selected a random number which you use to count passers by. If that number was five, you would approach every fifth person who passes you by.

In practice, in a busy shopping area with a wide pavement, this is not always so easy; and when there are very few people around, waiting for the fifth can feel like a frustrating waste of time. However, it is the preferred technique and should be followed if possible.

If you abandon this technique altogether, you may find that you end up by interviewing only those people who look friendly, and look like they have time to stop for an interview.

Depending on your topic, this can introduce an unacceptable bias into your survey. For example, in a survey where you want to find out how residents feel about their neighbourhood, approaching only ‘friendly’ people would certainly affect your results.

Street interviewing requires an outgoing and somewhat fearless personality. People are usually going somewhere or doing something, and time out to do a questionnaire has not been built into their schedule. For this reason, questionnaires administered on the street usually must be short, to the point and concerned only with factual information.

There are exceptions. For instance youth workers who want to obtain information about some of the young people on the street may find that the young people they approach are quite happy to respond to a long questionnaire.

There is no one technique that will work to get someone to stop for an interview. Below are a few suggestions:

- approach the person firmly and definitely so that they stop
- if you fall into step beside a person you reinforce their feeling that they are going in one direction and cannot vary;

- speak firmly and not too fast;
- make sure you are clearly identified with a badge label;
- make eye-contact and SMILE;
- wear average clothes that don’t send any particular message;
- indicate the length of the questionnaire, the reason you require the information and its benefits to the community.
Booking Interviews

The advantage of this method is that time is not wasted visiting empty houses or missing the respondent you want. However, if the interviewer calls beforehand, the householder may claim to be too busy, whereas had the interviewer just turned up on the doorstep, the householder may have agreed to be interviewed.

Older people, especially, respond well to booked interviews as it takes away the element of surprise which can be distressing.

Captive Populations

‘Captive populations’ are usually found in institutions, e.g. schools, or clubs where the same people meet regularly. By obtaining permission from the management and the people concerned, access can be gained to a number of people with a common interest or characteristic.

Schools are frequently used for this purpose. To find out about health issues affecting young people, it is a lot simpler to go to a school than to locate young people through, for instance, a household survey. Some schools have been researched to death and are reluctant to agree to new surveys unless they can see definite benefits accruing either to the school or to the students.

Getting Agreement for the Interview

Respondents can provide a number of reasons why they are unable to take part in an interview; these include ‘too busy’, ‘not interested’, ‘in the middle of dinner’, ‘watching TV’, ‘guests’, ‘cleaning’, ‘going out’, ‘not well’, ‘don’t know about the subject’, ‘new to the area’, etc.

It will be up to the interviewers to determine whether the person is willing to do the interview at another time. For instance, if the time is inconvenient the interviewer can offer to call back, arranging a time that is convenient. Always assure the respondent that:

- his or her opinion is very important, and;
- the questions are simple, and easy to answer.

Interviewers will have to make a judgement whether, after an initial refusal, they can continue with endeavours to secure an interview without offending the respondent. It is important that people who genuinely do not want to do the interview are not pressed, because this can only irritate them and lead to complaints about your organisation, and shows a lack of respect for those people.
Obtaining Interviewers

If you do not have the time or staff resources to conduct your own interviews, trained interviewers can be obtained from market research firms - but at a price. Community health workers usually have considerable interviewing experience and it makes good sense to draw on this experience.
CHAPTER 3 - Telephone Surveys

At first glance, telephone surveys may seem to be an easy option. After all, isn't there a ready-made population list from which to sample? Doesn't the problem of an attractive questionnaire disappear - as the respondent never sees it - and can't the interviewer make up for any deficiencies in clarity in the questions?

Telephone surveys can be relatively inexpensive, very fast and they can provide excellent quality control. However they are certainly not simple, and sampling for telephone surveys is not as easy as it may appear.

Advantages of Telephone Surveys

Quality Control

In face-to-face interviews, the following variables generally change with every interview:

- the location of the interview;
- distractions from the environment;
- the interviewer's appearance (clothes);
- the interviewee's appearance;
- tiredness due to interviewer travelling;
- the weather.

In telephone interviews, many of these distractions are avoided. Interviewers sit at the same telephone in the same surroundings with few distractions. Interviewers cannot influence the interviewee by their dress or body language. Also, if telephone interviews take place in a room with a supervisor, queries about questionnaire wording or possible prompts can be resolved immediately.

Telephone interviews minimise extraneous factors and provide a more standardised interview from the point of view of the interviewer. However, from the point of view of the interviewee, the situation could be full of distractions: for example, answering the phone dripping wet from the shower; checking that the soup doesn't boil over; wondering what the four-year-old is doing.
Cost

Because there is no need to travel to the interviewee, telephone interviews are cheaper than face-to-face interviews.

Speed

Telephone interviews are also quicker, firstly because there is no travel involved, and secondly because there is less time taken at the beginning and end of interviews in admiring furniture, saying goodbye, etc.

Disadvantages of Telephone Surveys

Questionnaire Length is Limited

People will not stay on the phone for an unlimited length of time; after fifteen minutes most people become weary and their replies tend to become shorter and less accurate.

Questionnaires Are Limited in Complexity

It is not possible to ask complicated questions by phone as respondents soon lose patience, especially if they have to ask for the question to be repeated.

It Is Not Possible to Make Use of Visual Aids

At least until the introduction of videophones!

Less Rapport Than with Face-to-Face Interviews

It is easier for interviewees to terminate interviews prematurely when they do not have to deal with the interviewer's physical presence.

Your Sample May Not Be Representative

By excluding people who do not have telephones, you may be excluding a poorer section of the population from your survey.
Selecting a Sample

Random Digit Dialling

One method of selecting a sample is through random digit dialling (RDD) whereby telephone numbers are selected by a random procedure. Market research companies have computer programs that will select these numbers for them, and there are software packages available to generate a random sample from a range of eligible phone numbers.

RDD provides equal probability of reaching a household regardless of whether or not the number is listed in the telephone book. The problem with this technique, for health workers who do not have access to a computer and the appropriate software, is the creation of the sample of random telephone numbers.

A sample of random telephone numbers can be created without a computer by selecting the range of eligible numbers (the front pages of the telephone book provides the range of telephone numbers for each suburb) and selecting from these by using a table of random numbers. The table, and how to use it, is provided in Appendix 3.1.

Fortunately, help is at hand from the Australian Bureau of Statistics. The ABS consultation service, for a fee, will help you to select a sample of numbers that will answer the needs of your survey.

Sampling from the Telephone Directory

Using the telephone directory to select a sample has serious problems. The directory contains superfluous numbers (businesses, double and triple listings, etc) and the numbers of people who have moved. It also excludes new residents and people with unlisted phone numbers, and so introduces an unknown bias.

If the situation arises when you feel the telephone book is the only, or most appropriate, source of a sample (perhaps for a needs assessment in a country town), you can select your sample by first of all randomly selecting pages and then randomly selecting numbers from these pages. Again, the best way to do this is by using a table of random numbers.
Making Contact

Some problems you may have include:

- **Non-Working Numbers**
  Go to the next substitute number.

- **Busy Numbers**
  Dial again later.

- **Answering Machines**
  Work out a standard response beforehand. Give your name and number, briefly state your purpose and telephone number, and when you are available. If your call is not returned, you treat this number as a 'no answer' and call back later.

- **No Answer**
  Make a note of the number and call back later or the next day. If the number continues not answering, and your time and resources are exhausted, move onto the next substitute number.

It is important to keep track of all this by using **Call Sheets**.

These are forms on which the interviewer records all the information relating to each call. The information that goes on each call sheet is:

- the interviewer's name;
- the telephone number;
- the time and day of each call to the number;
- the outcome of each call (answer, busy, no answer, out of order);
- record of substitute number if necessary to choose one.

When the interview is completed, the call sheet is attached to the questionnaire.

Selecting a Respondent

Selecting a respondent over the phone is similar to selecting a respondent for door-to-door interviews. If the purpose of the survey is to obtain information about the household that anyone can give, for example the number of children resident in the house who are under twelve years of age, then there is no reason not to interview the person who answers the phone. When attitude,
behaviour or knowledge is important, the interviewer should ask for a specific member of the household. This technique is examined in the previous chapter on face-to-face interviews. Determining a schedule of who to ask for is covered in this Section in Chapter 9 on Sampling.

**Obtaining a Telephone Interview**

Generally the rules for obtaining the respondent's agreement to an interview are similar to face-to-face interviews (see last chapter); however, there are additional hurdles to be overcome when the approach is by telephone.

When an interviewer stands at the front door, the householder can judge their legitimacy by their appearance and by looking at identification. No such procedure is available to the householder approached on the telephone. The telephone is essentially anonymous and it is not surprising that many people react suspiciously when they are asked to take part in a survey. This natural concern is increased by press reports of burglars and other criminals posing as researchers.

There are no easy ways to get over these problems. One approach is to send out a letter to respondents informing them of your intention to call at a specific time and the reason you are doing the survey. This approach is only possible when numbers have been selected from the telephone book.

If householders seem unsure, you can ask them if they would like the telephone number of the organisation doing the survey so they can check on the authenticity of the call.

It is important how your interviewers sound, as they will be judged by their voices. They should give their name, the full name of the organisation, and inform the interviewee of the purpose of the survey.

**The Interview**

The telephone interview is different from the face-to-face interview as there is no eye contact. However, lack of eye contact should not be a bar to establishing a degree of rapport with the respondent.

Generally the same cautions apply with telephone interviewing as with face-to-face interviews. The main difference is that the way the
questions are read becomes critical and interviewers have to guard against suggesting answers to respondents by the inflexion and tone of their voice.

The Questionnaire

A prerequisite of the telephone survey questionnaire is that it be simple and short. Having to ask for questions to be read again can irritate respondents or make them feel stupid. If respondents have difficulty understanding the questions, they will lose interest and terminate the interview.

In a telephone interview, respondents not only have to understand the question as it is read to them but may be expected to remember a list of answers from which they are to make a choice. For this reason, open-ended questions can be easier to work with over the phone than closed questions with alternative answers.

There can be a temptation with telephone interviews to run them off in a hurry without the same care that goes into either the mail questionnaire or the face-to-face questionnaire. The same care is necessary for all types of questionnaires. Silences on the phone as the interviewer works out where to go next, or in which box to put the answer, are disconcerting to both the interviewer and interviewee.

In telephone questionnaires it is an advantage to provide coding numbers that can be circled by the interviewers, saving the cost of further coding (see Chapter 8). If you decide on this method, make sure that your interviewers can do this without making a mistake. Some people prefer to have the interviewers tick question responses and then later have these coded. In this way there is a double check, and mistakes that cannot be rectified are avoided.

Training Telephone Interviewers

If you plan to use your own workers to do the survey, then it is important that sufficient time is put aside for workers to practise telephone interviewing techniques.

Once everyone is satisfied with the approach taken by the interviewers, then is the time to practise on the telephone. If possible, arrange for the interviewers to ring up people who they don’t know, as this will give them a better ‘feel’ for what it is like to conduct a phone interview.
When to Use a Telephone Interview

First of all, remember that telephone interviews generally are not suitable for collecting qualitative information.

The advantages of telephone interviews for the community health worker are speed and lower cost. When you need information in a hurry, then a telephone survey will obtain it more quickly than face-to-face interviews. If you cannot afford to do face-to-face interviews for the sample you require, then telephone interviews are certainly cheaper. However, they are not completely free and the cost of telephone calls mounts up.

There is some debate as to whether telephone interviews are more or less successful for collecting sensitive information. Some studies have shown that people are more willing to give out sensitive information when they cannot see the interviewer; other studies have shown the opposite. Perhaps it depends on the nature of the subject being surveyed. Our advice is to use your common sense and do a pilot study to find out how well your telephone survey works.

<table>
<thead>
<tr>
<th>Basic Steps in Telephone Surveys (Lavrakas 1986:18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decide on survey design, including sample size and sample selection.</td>
</tr>
<tr>
<td>Develop a draft questionnaire.</td>
</tr>
<tr>
<td>Draw up your selection of telephone numbers with substitutes.</td>
</tr>
<tr>
<td>Draw up a call sheet for each number.</td>
</tr>
<tr>
<td>Develop an introduction to be used by interviewers.</td>
</tr>
<tr>
<td>Select or hire interviewers and supervisors.</td>
</tr>
<tr>
<td>Pilot test the process and the questionnaire.</td>
</tr>
<tr>
<td>Make necessary revisions.</td>
</tr>
<tr>
<td>Train interviewers and supervisor(s).</td>
</tr>
<tr>
<td>Conduct survey.</td>
</tr>
</tbody>
</table>
CHAPTER 4 - Mail Surveys

Many surveys are conducted by mail. On a large scale, mail questionnaires are cheaper than interviewing either over the telephone or face-to-face.

When you use a mail survey, remember that:

* the questionnaire must appeal to those people receiving it and must encourage response;
* all instructions must be simple and complete;
* all questions must be simple, clearly worded and easily understood;
* records must be kept to allow follow-up of those people who don’t return the questionnaire.

A step-by-step guide to mail surveys is provided at the end of this chapter.

The Accompanying Letter

The letter you send with the survey requires considerable thought, for its purpose is to convince people of the importance of filling out the questionnaire and returning it to you.

The letter should tell respondents that it is important that they answer the questionnaire themselves, and that no-one else answer it for them - they might ask a friend or relative to fill it in on their behalf and that, of course, would be unsatisfactory. If someone else answers the questionnaire, the sample is no longer completely random, as another element of selection has crept in.

What are the characteristics of the accompanying letter? Your letter must:

* be brief and to the point;
* be easy to understand and not use lengthy or complicated words;
- deliver a message that is likely to appeal to respondents without compromising honesty;
- serve as an introduction to the questionnaire as well as an explanation of why the information requested in the questionnaire is needed;
- explain why they have been sent a questionnaire (e.g. their name has been randomly selected from the electoral roll), and to assure them that their answers are confidential;
- explain the enclosed reply-paid envelope.

Appendix 3.2 includes a copy of the letter that was mailed out with the Marion, Brighton and Glenelg Community Health Survey.

Posting

If your survey is large enough, it is possible that you will be able to obtain a discount by sorting your letters by post codes and delivering them in labelled bundles to your local post office. Check with the central post office as to current regulations on bulk mail. There are different types of bulk mail, so make sure that you exhaust all possibilities before paying full price for your survey letters.

You will need to use reply-paid envelopes. The post office will advise you of the format. You don’t pay for every reply-paid envelope you send out - just the ones that are returned. The post office keeps a record of this.

Good relations with your local post office are important. Later on you will be dropping in each day to pick up your mail when the completed questionnaires start coming in.

When there is a large number of questionnaires, addressing envelopes and bundling them up can be a time-consuming process and there is often considerable drain on staff and time. Don’t forget to allow for this in your time schedule and staff allocation.
The Questionnaire

All the information that respondents need must be included on the questionnaire itself. That is why we gave clear instructions on the cover of the Marion, Brighton and Glenelg Community Health Needs Assessment - as well as in the covering letter. This cover is depicted in Appendix 3.3.

Questionnaire design is detailed later in this Section, with specific mention of mail questionnaires. Briefly, when designing mail questionnaires, the most important things to remember are that:

- the questionnaire must be appealing and attractive and encourage response by its layout;
- the respondent has no one to turn to if he or she can’t understand the questionnaire or any particular question - therefore question wording and instructions must be simple, clear and fully explanatory;
- questions must appear relevant because if the respondent starts to doubt the relevance of some of the questions, he or she may stop answering the questionnaire.
Questionnaire Identification

Although you will not be interested in who sent what reply - and neither should you be, as the assumption in all surveys is that no information is traced back to an identified individual - you will need to know which respondents have replied so that those who have not responded can be sent a reminder notice.

For this reason, each mailed questionnaire will need an identification number. This is done by giving each person in the sample a number which is recorded on the front of the questionnaire. As questionnaires are returned they are crossed off the list.

Reminder Notices and Response Rate

The method of sending out a questionnaire with a letter and following it up with reminder notices has been described by Dillman (1983).

Following this method, the Noarlunga Community Health Needs Assessment received a response rate (returned and completed questionnaires) of 74%, while in Marion, Brighton and Glenelg the response rate was 71%.

After you send out the questionnaires, it is time to think about preparing a reminder card to send to those people who have not returned their questionnaire, i.e. those who have not been crossed off the master list.

This first reminder can be in the form of a post card or a letter. In the Marion, Brighton and Glenelg Community Health Needs Assessment, we sent reminder post cards in the same colour as the questionnaire. For the Lower North Community Health Needs Assessment, a letter was sent. A copy of the card and of the letter are shown in Appendices 3.4 and 3.5 respectively.

The first reminder card should go out between ten days and two weeks after the original posting. Two weeks later, this card will be followed up by another questionnaire, with an accompanying letter stressing the importance of the survey and asking the respondent to use the new questionnaire if they have misplaced the first one. A copy of the accompanying letter we used is included in Appendix 3.6.
It is up to you whether you wish to repeat this process a third time and it will depend on the response rate you have obtained, your resources and your time schedule.

In the box below is a graph relating response rate to time and date of posting of reminder cards for both the Marion, Brighton and Glenelg, and the Noarlunga, Community Health Needs Assessment.

**RESPONSE RATES FOR THE MARION, BRIGHTON & GLENELG AND NOARLUNGA NEEDS ASSESSMENT**

- Noarlunga Survey 1985
- Marion, Brighton & Glenelg Survey 1987
The Supplementary List

This is a list of supplementary names to replace people in the original sample who have died or moved (remember that refusal is not grounds for replacement). This list of further names is obtained in the same way that you obtained your main sample (see Chapter 10 of this Section).

A Step-By-Step Guide to Mail Surveys

1. Design the questionnaire.
2. Decide on the size of the sample.
3. Test (pilot) the questionnaire.
4. Print the final form of the Questionnaire.
5. Select the sample, e.g. from the electoral roll.
6. Record the names and addresses of sample members and allocate identification (ID) numbers.
7. Label each questionnaire with an ID number.
8. Type up labels for posting.
9. Print or type pre-paid return envelopes.
11. Post out questionnaires with covering letter and reply-paid envelope.
12. Mark off questionnaires as they are returned.
13. Draw up a supplementary list of people (randomly selected) to replace sample members whose questionnaires are returned because they have either moved or are deceased, and send these out as required.
14. Send out the first reminder to those who haven’t replied.
15. Send out the second reminder and fresh questionnaire to those who haven’t replied.
16. Draw up a coding frame and allocate code numbers for the answers to each question.
17. Go through the questionnaires transferring answers into codes onto coding sheets.
18. Type the codes onto computer.
19. Analyse the results.
20. Write the report.
Warning!

The following newspaper item suggests that several requirements for a successful mail survey were not followed, resulting in a strongly negative response from the community being surveyed. This shows the importance of careful planning and preparation before undertaking a survey.

Outcry at 'prying' survey into community services

A SURVEY aimed at finding out whether people in Maslin Beach are happy with services in the area has been blasted by residents as an "invasion of privacy".

A 17-page questionnaire, written by Willunga Council’s community services section, was handed out to more than 300 houses in Maslin Beach recently.

The survey asked for information on subjects ranging from marital status and employment to the number of doctor's visits made in the past 12 months.

Council had discussed the need for a study of the area in April this year and passed a motion that a study be done.

But residents said they were annoyed and angry at the way the survey was handled.

Maslin Beach Ward councillor Margaret Stapley said she was annoyed she was not told that the survey was coming.

"I am absolutely astounded at the way this has been handled," she said.

"There was no warning that this was coming out, no forwarding note and not even an envelope to send the thing back.

"As the ward councillor I would have thought I would have been consulted about this.

"The questionnaire was supposed to be confidential but there was a number pencilled in on the form."

Maslin Beach Community Association member Dorothy FraterMcCarthy said many Maslin Beach residents were angry that their privacy was being invaded by the survey.

"I can't understand why this has been put out," she said.

"One woman had told me that she had torn it (survey) up.

"This is an infringement of of people's privacy - why should I tell Willunga Council if I had seen a psychiatrist lately."

Other residents Susan Vignoni-Squire and Beryl Adams said they were concerned that the survey was not confidential.

Stop the survey! Maslin Beach resident Susan Vignoni-Squire was one of many local residents annoyed about a council questionnaire circulated in the area. The residents say the survey was an invasion of their privacy.

Willunga chief executive officer Kym Just said a written apology had been sent to all Maslin Beach households. "Unfortunately the questionnaire was delivered without any supporting information which has caused concern among some householders within the Maslin Beach community," he said.

"There is absolutely no compulsion for any householder to complete the questionnaire either in part or in entirety.

"And the pre-numbering of the questionnaires was in no way intended to relate collected data to any particular household, but was used solely to identify varying needs that may exist in the township, according to locality."
CHAPTER 5 - Introduction to Questionnaires

Questionnaires are used for many different purposes and they come in different shapes and sizes. Whatever the use or the format, they all have the common factor that they are concerned with collecting information, and the same broad design rules apply to them.

A well-produced questionnaire looks as if it has been easy to design. The truth is that the final version of a properly planned questionnaire has gone through several drafts and is the result of a good deal of thought and hard work.

The writing of questions and the construction of a questionnaire needs sufficient time and thought regarding:

- the purpose of the questions;
- whether the answers you are likely to get will provide the information that you want; or even
- whether you will get any answers at all.

Questionnaire planning is crucial because the design of the questionnaire, and the way the questions are worded, will affect answers.

For instance, ‘What is your income?’ at the beginning of your questionnaire can put people off; or by demanding a ‘yes’ or ‘no’ answer to questions that respondents would prefer to qualify, you run the risk that they will opt out of your survey.

The way you word your questions, and the sequence you put them in, can determine the answer you receive, as the mock survey from Yes Prime Minister on the next page shows.

Before you start to design your questionnaire, you will need to know if it is to be self-administered or presented to respondents by interviewers, either over the phone or face-to-face. The differences between these types of questionnaires are examined in the following chapters.

In Chapter 6 of this Section, we look at the various types of questions, while in Chapter 7 we go through the process of how to write a question, and examine the qualities of a ‘good’ question. In
Chapter 8 we look at the rules for putting the questions together to make up a questionnaire.

Extract from Yes Prime Minister (Lyn & Jaw:1986)

The people are/are not in favour of reintroducing National Service

‘Mr. Woolley, are you worried about the rise in crime among teenagers?’
‘Yes,’ I said.

‘Do you think there is a lack of discipline and vigorous training in our Comprehensive Schools?’
‘Yes.’

‘Do you think young people welcome some structure and leadership in their lives?’
‘Yes.’

‘Do they respond to a challenge?’
‘Yes.’

‘Might you be in favour of reintroducing National Service?’
‘Yes.’

‘Are you worried about the danger of war?’
‘Yes,’ I said quite honestly.

‘Are you unhappy about the growth of armaments?’
‘Yes.’

‘Do you think there’s a danger in giving young people guns and teaching them how to kill?’
‘Yes.’

‘Do you think it wrong to force people to take up arms against their will?’
‘Yes.’

‘Do you oppose the reintroduction of National Service?’
I’d said ‘yes’ before I’d even realised it.
CHAPTER 6 - Types of Questions

Questions may be either:

- open-ended, or
- closed.

They can deal with either:

- factual/behavioural, or
- attitudinal issues.

Open-ended and Closed Questions

A ‘closed question’ is one where the respondent is limited to a restricted number of replies; for example:

Are you male? □

or

female? □

is the simplest version of a closed question, while;

What sex are you? ....................

is the simplest version of an ‘open-ended question’.

Generally the majority of questions in a questionnaire are closed because they are easier to code and analyse, and they are also usually easier and quicker to answer.

If we wanted to find out what the people in a neighbourhood thought about the public transport system in their area, we might ask the open-ended question:

What do you think about public transport in your area?

Almost every respondent would give a different answer. Some might simply give one word answers such as ‘terrible’ or ‘okay’, while others (depending upon the space that was made available for answers) might write a couple of paragraphs on their experiences with the bus or train service. When we analyse this information, we have no way of knowing what there was about the system that was ‘terrible’ or ‘okay’. Was it the frequency of the buses, their punctuality or their cost? Thus open-ended questions can sometimes provide less information than closed questions.
What sort of closed questions could we ask about public transport? In the box below are two questions on transport.

At the end of Question 37 you will notice that we have given the respondents the opportunity to tell us if there is anything we have missed. In this way we have tried to overcome one of the disadvantages of closed questions, which is that they can close out important information.

**QUESTION 36**

Do you use public transport (trains, buses, trams)?

Every day

Once or twice a week

Occasionally

Never

**QUESTION 37**

Would you use public transport more if:

(Please tick the most appropriate answer in each line)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The bus/train/tram ran more frequently?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>The bus/train/tram ran on time?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>The bus/train/tram stop was closer to your home?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>There was someone to help you get on the bus/train/tram?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fares were cheaper?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Connections were better?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other (please state)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

124
Another example of a closed question:

I would like the Parenting course . . .
(Please tick one or more boxes)

to be on a different day. □
to be at a different time. □
to have more open discussions. □
to examine actual cases. □
to invite more experts. □
other (please specify) __________________________

Advantages and Disadvantages of Closed Questions

(Adapted from Bailey 1978)

Advantages

- Answers are standard so they can be compared from person to person.
- Respondents are clearer about the meaning of the question because they can tell from the answer categories what is expected.
- Answers are more likely to provide the information being sought.
- Closed questions can help elicit sensitive material, e.g. income.
- They are easier to answer, code and analyse.

Disadvantages

- Easy for respondent to guess 'appropriate' answer or to answer randomly.
- Respondent may feel frustrated because the appropriate category for his/her answer either is not provided at all or is not provided in sufficient detail.
- Can be too many categories.
- Can entail irretrievable loss of information, as all we have is ticks in boxes.
May miss some crucial element because it was not included in the question.

Makes a questionnaire look longer.

Advantages and Disadvantages of Open-Ended Questions

Advantages

- Can be used when all responses are not known, or when the researcher wishes to see what that respondent views as appropriate answer categories.

- Can be used when there are too many potential response categories.

- Preferable for complex issues that can't be condensed into a few small categories.

- Allows respondent to provide sufficient detail to clarify their answer.

- Allows the respondent more opportunity for creativity in their answers.
Disadvantages

- Collection of irrelevant/useless information.
- Data are not standardised therefore analysis is much more difficult.
- Coding difficult - subjective.
- Requires higher writing skills from respondent.
- Generally only suitable for interviewer questionnaires.
- May lead to higher refusal rate, because it requires more of respondent’s time and effort.

Generally, questionnaires are a mix of open-ended and closed questions. Closed questions should be used where the answer categories are discrete, distinct and relatively few in number; also, there should be an opportunity at the end of the questions for respondents to add information that may have been missed.

Factual Questions

Factual questions are often the easiest types of questions to ask, especially in self-completion questionnaires. However, even seemingly straightforward factual questions can be problematic, for example:

When did you leave school?

This looks straightforward enough. But what sort of answers are we likely to get?

‘1963’
‘Year 9’
‘When I was 15’
‘Before Matriculation’
‘After Intermediate’
‘Didn’t, still at school’

Analysing this would be a nightmare. A more precise answer could have been obtained by asking:

At what age did you leave school?

Although this also has drawbacks. It does not elicit the level of education reached, and a respondent who had continued on to tertiary education would not know whether tertiary education was included as school or not.
A more precise question might be:

At what age did you finish your full-time education?

But this too has problems as it omits students who studied part time. Below is how we handled this question (MBGCHNA Questionnaire).

QUESTION 26

What is your highest level of education?

- No Formal Schooling
- Primary School
- Secondary School (High, Tech, etc.)
- Trade or Business Qualification
- Degree or Tertiary Diploma
- Higher Degree

Attitudinal Questions

As well as discovering factual information about people, we often need to know about their attitudes to various things - for instance how they feel about their neighbourhood, their health, or the medical services they receive. To obtain this type of information we ask attitudinal questions.
Attitudinal questions are generally more difficult to design than factual ones, primarily because they deal with abstract concepts that are difficult to measure. Most often, attitudes are best explored using the qualitative techniques described in Section 4. There are, however, methods that can be used to collect simple attitude data in a questionnaire.

**Verbal ratings**

In this type of question, respondents are asked to rate something between two extremes, such as ‘very noisy’ and ‘very quiet’, or ‘very concerned’ and ‘not in the least concerned’.

In the box below is a question from the Marion, Brighton and Glenelg Community Health Needs Assessment which used this technique:

<table>
<thead>
<tr>
<th>(a) VERY QUIET</th>
<th>VERY NOISY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(b) VERY CLEAN</th>
<th>VERY DIRTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(c) A VERY FRIENDLY PLACE TO LIVE</th>
<th>A VERY UNFRIENDLY PLACE TO LIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(d) A VERY ATTRACTIVE PLACE TO LIVE</th>
<th>A VERY UNATTRACTIVE PLACE TO LIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(e) A VERY SAFE PLACE TO LIVE</th>
<th>A VERY UNSAFE PLACE TO LIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Attitude scales

In this type of question, respondents are asked to indicate their attitude to something by selecting between two extremes of attitudes, such as 'not important' and 'very important'. In the box below is an example from the Marion, Brighton and Glenelg Community Health Needs Assessment:

<table>
<thead>
<tr>
<th>Activity</th>
<th>NOT</th>
<th>NOT</th>
<th>QUITE</th>
<th>VERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not adding sugar to your tea or coffee</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Avoiding soft or fizzy drinks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Trimming the fat from meat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Grilling meat rather than frying</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Substituting white meat (poultry) for red meat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Substituting polyunsaturated margarine for butter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Not adding salt to your food at the table</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Eating more whole-grain rather than white bread</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Adding bran to a meal every day</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

... (AND SO ON) ...
Statement Ratings

In this type of question, the respondent is asked to rate how true or false she or he sees a certain statement about the subject under investigation. For example:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True</th>
<th>Quite True</th>
<th>Neither True nor Untrue</th>
<th>Not Very True</th>
<th>Not True at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Practical</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Informative</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Fun</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Enjoyable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>What I Wanted</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>What I Expected</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Good on Theory</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Professionally Run</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Too Much Detail</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>A Waste of Time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Image Statements

This type of question is a subset of Statement Ratings, the focus being on the image of an activity. Respondents provide us with their impression of a subject by rating ‘image’ statements as ‘true’ or ‘false’. For instance, if community workers were trying to assess how teenagers felt about marijuana, they might include the following question in a questionnaire:
Please state by circling a number from 1 to 5 whether you find the followings statements - true, mostly true, neither true nor false, mostly false, false - about marijuana (dope, grass):

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mostly True</th>
<th>Mostly False</th>
<th>Neither True nor False</th>
<th>Mostly False</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad for your health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Used by most people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Glamorous</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Expensive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Cheap</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Good for you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Only for losers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Used mostly by rich people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Used by most pop stars</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Approved by doctors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Used by sporting people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Good for relaxing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Used by everyone who can afford it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>First step to heroin use</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Used by successful people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Better for you than alcohol</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Not as bad for you as tobacco</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Not as bad for you as people like to make out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Sentence Completion

This type of question is more open-ended than most attitude questions. The respondent shows his or her attitude by completing a sentence about the subject. For example:

So far, I think this workshop .................

When to Use What

There are no hard and fast rules that will tell you when to use a particular style of question. The information you want to obtain is what determines the approach to use. Try the various approaches and the one that elicits the information you want is the one to use.
CHAPTER 7 - Writing the Question

The last chapter provided an indication of the range of questions you might use. Now we need to explore the rules for starting from scratch and writing the question yourself. Below are some of the Dos and Don'ts.

The Dos

Keep It Short and Simple

The shorter and simpler the question, the less chance of misunderstanding.

- Where possible, use well-known single-syllable words; for example:

  Do you have high blood pressure?

  rather than

  Do you suffer from hypertension?

  Remember, literacy levels differ throughout the community and you want everyone to be able to read and understand your question.

- Use concrete terms in preference to abstract terms, for example:

  How (car, foot, bus etc.) did you get here today?

  rather than

  What form of transport did you use to travel here today?

- Use simple direct sentences, for example:

  Do you have a car to use on weekends?

  rather than

  Thinking of what is usual at your house, would you say that normally you have access to a car at the weekend?
Try to word questions positively, for example:

Do you agree that people with lung cancer should get free health care?

rather than

Do you agree that people who develop lung cancer should not be made to pay for their health care?

Make Sure the Information You Obtain is Usable

Questionnaires designed in a hurry can go terribly wrong as the following example shows.

The researchers in a project wanted to check awareness of services and how people got information about these services.

The first question asked:

Please tick the services you have heard about.

and gave a list of 20 services.

The question immediately following asked:

How did you find out about these services?

Some more thought would have revealed that the information in the second question was unusable as the researchers would not know to which services the answers referred.

Only Seek Information that You Know Will Be Used

Questionnaires do not operate like a lucky dip - you can’t toss questions in, in the hope that they may turn up something interesting. You should understand what information you want from a question, and word it so that you obtain it.

Make Sure the Question Can Be Answered by All Respondents

This seems obvious enough but it is surprising how many questions do not meet this requirement.
Sometimes a question may not apply to everyone answering the questionnaire. Make sure you exclude people for whom the question is inappropriate.

Provide a ‘don’t know’ category for people who may not be able to provide an appropriate answer to the question.

Where questions are closed, i.e. a specified range of answers is provided, make sure that the answers cover all possible options and offer the category:

Other □ please specify ...........

Be Specific

The question:

Does your school have a policy on drugs?

might look good because it seems so economical. Unfortunately, the answers you get will be difficult to analyse unless you specify each drug in turn; for instance:

Does your school have a policy on cigarette smoking?

YES □ NO □

If YES, What is it? ............... Does your school have a policy on marijuana?

and so on.

Test Your Question

This is the most important rule of all. First of all test the question on yourself. Make sure all your answers provide the type of information you are seeking. After you have tested the question on yourself, test it on someone else who is not involved with its design.
The Don’ts

Don’t Assume that Respondents Will Know What to Do

In mail questionnaires, instruct respondents where to place their ticks. Inform respondents which question to go to next if there is any possibility of doubt. If there is any chance of confusion give a clear example.

Don’t Ask Ambiguous Questions

Please tick the following services you know about.

In this question ‘know’ is ambiguous. It could be interpreted as ‘heard of’, or respondents may interpret it to mean ‘aware of the type and range of services offered’, or even ‘have used’.

Don’t Inadvertently Offend Anyone

For example:

Should single mothers be separated from married mothers in ante-natal classes?
Don’t Use Double-barrelled Questions

Double-barrelled questions treat two or more separate pieces of information as one; for example:

Does your Community Health Centre have a special recruitment policy for racial minorities and women?

Don’t Force Respondents to Make Choices They May Not Want to Make

For example:

Would you prefer to see a doctor or a nurse when you have a minor illness?

Don’t Ask Leading Questions

For example:

Have the changes to bus schedules made it more difficult for you to use public transport?

One way of inadvertently asking leading questions is to use emotive terms; for instance:

Do you think the frail elderly should be provided with a community bus?

is more emotive than:

Do you think that elderly residents who have difficulty walking more than short distances should be provided with community buses?

Don’t Use Jargon

The question:

Do you think your community would benefit from a community development program?

may be meaningful to members of a community health centre, but most local residents would not be familiar with the term ‘community development’.
Don't Assume Anything

From a survey on health care, the question immediately following one on household composition was:

In which suburb is your family doctor located?
(Please write in:) .........................

Some people may not have a family doctor.

On the next page is a step-by-step guide to creating your own questions.
CREATING A QUESTION: STEP-BY-STEP

1. What information do I want from this question?

2. What is the most direct question that will obtain this information?

3. Does this question satisfy all the requirements of a good question? Is it:
   - Short and simple?
   - Specific?
   - Answerable by all respondents?
   - Going to provide useful information?
   - Worded to provide the desired information?

4. Does it avoid:
   - Making assumptions?
   - Ambiguity?
   - Jargon?
   - Forced choices?
   - Asking for more than one piece of information?
   - Leading respondents?
   - Being offensive?

5. What range of answers am I likely to get?

6. Do all these possible answers seem to provide the type of information I am looking for?

7. Can I analyse the answers to this question to get the information I want?

   YES        NO  (try again)

   Test questions on someone else.
CHAPTER 8 - Putting the Questionnaire Together

Having written all your questions, the next step is to put them together in a good workable questionnaire.

Many of your questions will have been written as part of a sequence; but there will be extra questions which have to be fitted into a sequence, and frequently such sequences of questions will need to be re-arranged.

Layout

The type of survey you are using - mail, telephone or face-to-face - will determine, to some extent, how you set out the questionnaire. Layout is important, whatever the type of interview, as interviewers need a clear easy-to-follow layout as much as the respondent does. If the interviewer stumbles over a question, then the interview will not proceed as smoothly as it should.

Key features of all good questionnaires should be:

- clarity;
- simplicity of design;
- explicit instructions.

If questionnaires are to be filled in by respondents, they should appear simple and attractive. A complicated, compressed layout, with little space on a page, is almost certain to be less inviting than a longer questionnaire with ample space for questions and answers.

Mail Surveys

The following rules will serve as a useful guide for designing self-administered questionnaires.

- Use a plain easy-to-read type face, and if the questionnaire is to be self-administered by elderly people, make sure your type is large.

- Leave lots of space between questions so that the questionnaire does not look cramped, but has an open, airy look.
• Consider cartoons. Cartoons keep respondents interested. This is especially important when the questionnaire is lengthy or time consuming.

• Do not pre-code your questions. Although it makes coding much easier at a later date, the inclusion of codes make a questionnaire look intimidating and 'busy'.

**Interviwer-administered Questionnaires**

**Display Cards**

Generally the respondent will not see the interview sheet that the interviewer is using. To solve the problem of fixed alternative answers, these can be printed on cards and shown to the respondent. The interview would proceed like this:

**INTERVIEWER:** ‘Which word or phrase on this card best describes your marital status? Are you . . .’

(Display card and read:)

- Single?
- Married?
- Living in a de facto relationship?
- Separated?
- Divorced?
- Widowed?
- Other? (If respondent replies ‘Other’, ask: ‘What do you mean by other?’)

The display card is particularly useful in interviewer-administered questionnaires when there are attitude questions. The printed card
can be used to display the five categories, for example:

<table>
<thead>
<tr>
<th>VERY SATISFIED</th>
<th>NEITHER SATISFIED</th>
<th>DIS-SATISFIED</th>
<th>VERY DIS-SATISFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SATISFIED</td>
<td>NOR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The respondents have the card in front of them to remind them of the rating categories. This is also useful if there are several things being rated, for example different services.

Space

When recording open-ended answers, the interviewers will write quickly and not necessarily neatly. Make sure that there is enough room for him or her to record everything that the respondent says.

Pre-coding

To save time later, it is usually convenient to include a list of codes next to the answers; for example:

‘How old are you?’

For office use only.

17 - 24
25 - 34
35 - 44
45 - 54
55 - 64
65 - 74
75 +

When you do pre-code a questionnaire, make sure that no categories are left out of your question, and that each category does not overlap with another.
Telephone Surveys

The telephone survey questionnaire has to be designed so that the interviewer can move through it quickly and efficiently, with no awkward pauses.

Questions and question sequences should sound as natural as possible and be easy to answer, with very little remembering required by the respondent.

Fixed alternative answers and attitudinal questions are particularly difficult in telephone questionnaires as the respondent is totally dependent on verbal information.

The way to deal with this is to keep your fixed alternative answers to a minimum so that there are not too many to remember, and instruct the interviewer to repeat the list of alternative answers, for instance:

INTERVIEWER: ‘What is your marital status? Are you . . .’
   Single?
   Married?
   Living in a de facto relationship?
   Separated?
   Divorced?
   Widowed?
   ‘Or is there another description that best describes your marital state? I’ll read that list again. Are you . . .’

One way of dealing with rating questions in telephone surveys is to divide them in half. For instance, you might ask:
‘Is it important or unimportant to have services for the elderly?’

If the respondent says ‘Important’, ask: ‘Is it important or very important’; if the respondent says ‘Unimportant’, ask ‘Is it unimportant or very unimportant?’

The telephone interview form would look like this:

INTERVIEWER: ‘Do you think council services for the elderly are important or unimportant?’

If the respondent says ‘Important’, ask:
   ‘Are they important or very important?’

If the respondent says ‘Unimportant’, ask:
   ‘Are they unimportant or very unimportant?’
The questionnaires should be set out in a way that helps the interviewer follow them through quickly and easily; if the interviewer stumbles, the interview stumbles.

As these questions are given by voice, they must be very easy to understand, with no long complicated questions. Respondents should not have to ask the interviewer to repeat questions.

A General Guide to Questionnaire Design

Take special thought over your first question, as respondents will sometimes judge the whole questionnaire by the first question. The first question should be:

- easy to answer;
- applicable to everyone;
- relevant to the topic;
- interesting;
- socially important or obviously useful information;
- not too personal.

Put sensitive questions later in the questionnaire. Sensitive questions at the beginning of the questionnaire can be very threatening as they come before the respondent has some understanding of what the questionnaire is about.

Avoid a sequence of questions which could prejudice the answers to succeeding questions. The excerpt from *Yes Prime Minister* in Chapter 5 is an example of a deliberately biased questionnaire. An unconscious or unintentional bias is more common.

Give clear instructions on where to go next. In the questionnaire extract on the next page, respondents who said ‘No’ to the first part of Question 1 were clearly directed to Question 3. This was because the second part of Question 1, and all of Question 2, were relevant only to those people who had answered ‘Yes’ to the first part of Question 1.
1. Were you sick, injured or feeling unwell at all in the last two weeks?

   YES [ ]
   NO [ ] → Go to Q. 3

If YES,
What was the cause of this?

(Please tick one or more answers)

COLD, FLU, SORE THROAT OR VIRAL INFECTION ............... [ ]
STOMACH OR BOWEL PROBLEMS .................................... [ ]
ACCIDENTAL INJURY ................................................ [ ]
BACK-STRAIN OR PAIN ............................................. [ ]
HEADACHE ............................................................. [ ]
DEPRESSION .......................................................... [ ]
OTHER (please state) ................................................

Leave plenty of room for answers to open-ended questions.

For example (MBGCHNA QUESTIONNAIRE):

QUESTION 24

If working full or part-time, what is your job?

(Please describe as fully as possible, e.g. not just 'clerk', but 'clerk, Class 1 in the Department of Environment'; not just 'mechanic', but 'motor mechanic at garage').

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
Use simple short words for your directions and your questions. Avoid long words, unusual words, and jargon. You want as many people as possible to answer your questionnaire; therefore use words that the greatest number of people will understand.

Use simple, direct sentences in your instructions as well as in your questions.

Allow room for comments at the end of the questionnaire.

For example (MBGCHNA QUESTIONNAIRE):

QUESTION 47

Are there any other comments you would like to make about health, welfare and community services in your area?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

QUESTION 48

Have you any comments you would like to make about this questionnaire?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Always pilot (pre-test) your questionnaire.

This is the most important rule of all. Once you have a questionnaire that you are happy with, give it to interviewers to try out. Interviewers will give good feedback from themselves and respondents. Your questionnaire should be tested with a variety of people. These people should answer the questionnaire in conditions similar to those that will apply in the actual survey.
How many respondents should be in your pilot study? This is up to you, but certainly no less than 20, and in large studies (over 1000) 50 is a safer number.

After your test-respondents have filled in the questionnaires, ask them if they had any queries or difficulties with any of the questions.

Code and analyse the results of your pilot questionnaire as you would the final survey to detect any flaws or problems. The questionnaire may work quite well in the field but may provide difficulties at the stage of analysis. A few changes may make analysis easier without harm to its effectiveness in the field.

Once you have changed your questionnaire, test it again: you may have introduced more problems with your changes!

Questionnaires for Special Groups

The following are key points which need to be considered in designing a questionnaire for special groups. These points are illustrated in Appendix 3.7.

Key points include:

- collaboration with these groups in such a way as to ensure that they do not become ‘the researched’;

- questionnaire must be culturally and linguistically sensitive to nuances of meaning in the key words used;

- methodology must be appropriate for the group; for example, do not use self-completed questionnaires for a group with a high proportion of people whose writing skills are limited;

- methodology must be designed collaboratively;

- avoidance, or at least minimal use, of instruments that have been standardised on other groups; for example, psychologically-oriented tests for gauging anxiety;

- acceptability of interviewers to special group.
CHAPTER 9 - Samples

If you want to know how a pot of food tastes, take a spoonful. You don’t need to eat the whole pot! (Feuerstein 1986).

We liked this example of Feuerstein’s so much we thought we would include it in this Manual.

To extend Feuerstein’s analogy just a little: when a stew is made up of a lot of different ingredients, it is important to know that your taste was representative of the whole stew and not just the piece that happened to be captured by the spoon.

Samples are by their nature estimates. Sometimes in research we need a great deal of precision in our estimates; at other times this high degree of precision is not so important.

As our need for accurate estimates increases, so does the size of our sample and the amount of work we put into selecting it. The next chapter looks at setting sample size. In this chapter we take a look at how you go about selecting a sample.

Using Samples in a Community Health Setting

Let’s have a look at a simple example of community health research:

Believing there was need for occasional child care in their area, community health centre workers knocked on doors questioning residents about their need for occasional child care.

The workers found that out of 50 houses surveyed, seven (14%) said they needed occasional childcare. Extrapolating to the population of 1000, the workers concluded that approximately (samples of this size provide only approximations) 140 people in the local area would use occasional child care: enough to justify providing a service.

This example has been simplified to make a specific point. In the real world, the community health workers would extend their research before making a decision. For example, they might check with the staff of relevant organisations such as the Children’s
Services Office to determine if their experience in that area supports the results of the door-knock survey.

But getting back to the point of the example: was their conclusion justified? Almost certainly, unless there was a bias in the way the workers selected their sample or in the way they asked their questions.

The way samples are selected is crucial. For instance, if the community workers had gone to the first 50 houses they came to, they would not have been able to make a statement about the needs of the whole neighbourhood, only about the needs of the street they surveyed.

Similarly, if the community workers visited randomly-selected houses only during the daytime, their sample would have been biased. In such a case, the workers would have been able to conclude only that 14% of residents at home during one particular day required occasional child care. Thus it would not have been possible to work out what was the number of occasional child care places needed by the community as a whole.

Common sense would suggest that community workers should go into the community at different times and that houses should be selected on the basis of a random sampling plan. Sampling plans must ensure that every household in the neighbourhood has an equal chance of being included in the sample.

Community workers are often wary of the amount of work and technical detail that is involved in quantitative surveys. However, when you know what you are looking for, when the information required is straightforward and simple, and you are working with a small local area, then common sense is usually the only guide you need.

When you want answers to a number of questions, when the topic is complicated, when you are sampling from a large population, or when you need great precision in your results, then you will need to know more about how to select random samples and what size sample is sufficient to provide valid conclusions.

But before we start, some good news. If you are in any doubt about sample selection, the Australian Bureau of Statistics’ Statistical Consultation Service will help you select the sample you need. The telephone number for your State can be obtained from your local capital city telephone directory.
Selecting a Sample

Your sample has to be representative of your population; the way you select it has to ensure that there are not sections of the population you wish to study, which have been excluded from the sample because of the way you have selected it.

If the way you select your sample is biased, then your results also will be biased and of little use.

The Random Sample

In most cases, this will be the method you use for selecting a sample. If you want to select a sample of ten from a population of 50, you could put all the names (or addresses, or representative numbers) in a hat, mix them around, and pick out ten names. The sample selected by this method is known as a simple random sample.

There are other methods of selecting random samples. See Appendix 3.1 for instructions on selecting a random sample using a random number table. However, we have found that in most cases the hat method, or systematic sampling as described below, is satisfactory.

For the Marion, Brighton and Glenelg Community Health Needs Assessment, we wanted a sample of 2500. Our population was the local government areas of Marion, Brighton and Glenelg. To select the sample, we obtained the electoral rolls for the three councils. The total number of electors registered was 80,000. As 80,000 divided by 2,500 is 32, we had to include every 32nd name in the sample. We did not start at the first name on the list, as this would have meant that the first person on the roll would automatically be selected. What we did was draw up 32 numbers and put them in a hat. We then drew out a number from the hat to act as our starting point. That number was 27. We counted 27 names down the electoral roll, recorded that as the first name in our sample, and then took every 32nd name after that.

The system described above, where a name is selected at regular intervals from a master list, is known as systematic sampling.

In the Marion, Brighton and Glenelg Community Health Needs Assessment, we tried to make our sample as random as possible. However, by using the electoral roll we skewed our sample, as the
The electoral roll does not contain the names of those people who have not registered as electors. This meant our sample excluded people under 17 years of age (young people can put their names on the roll at 17 even though they cannot vote until 18), migrants, and anyone who, for whatever reason, was not on the electoral roll. Because of these limitations, we restricted the aims of the survey, acknowledging that we were not surveying the whole community but only those people over 17 years of age who were on the electoral roll. Although this was not ideal, there were no other options open to us that were as cheap and as simple.

Aware of the limitations of our population survey, we assessed the needs of the under-17s using a wide range of qualitative methods, including reports from schools and organising interviews with young people in shopping centres and other key locations (using other young people to do the interviewing). Although Marion, Brighton and Glenelg do not contain a large ethnic population, we were concerned about migrants and people who would not have been covered by the survey, and through our qualitative methods (Focus Groups, Nominal Group Technique, Delphi Technique), made every attempt to ascertain their needs.

It is worth noting that if we had been doing a survey of the community’s attitudes to compulsory voting, using the electoral roll would have produced a totally unacceptable bias.

There are other lists that you can use depending on the population from which you are sampling. In the Marion, Brighton and Glenelg Community Health Needs Assessment, we were sampling from the general population, so we used the best list of the general population we could find. Sometimes specific populations will have their own sources, e.g. diabetes sufferers. Once you do obtain such a list, make sure the list is complete before you start to select your sample. Also make sure that it is ethical to use such a list for survey purposes.

You can also select a sample ‘with your feet’. If you want to survey a community of 1,000 houses and you have decided on a sample of 200, you could draw up a plan so that you walked around every street in the neighbourhood, stopping at every fifth house.

However, this type of sample selection has other problems. What about the people who aren’t at home? Do you have to keep going back and back again? Read on.
The Cluster Sample

A cluster is a number of things of the same sort gathered together. School children naturally cluster in schools and, within schools, cluster in classes. To obtain a random sample of school children, we would select a random sample of schools (by a simple random selection or by systematic selection, whichever method was preferred), and then within the schools randomly select a number of classes, and from those classes randomly select a number of children.

Populations are clustered in Local Government Areas, Post Code areas and Census Collection Districts (CDs). It is this latter group, being the smallest, that is most frequently used in selecting a sample of households (there are approximately 200 households per CD, and approximately 5000 CDs in metropolitan Adelaide).

The Australian Bureau of Statistics’ Statistical Consultation Section in your capital city will help you select a cluster sample based on CDs. This is by far the preferred way of going about obtaining a cluster sample of households because ABS can use their computer to generate a sample in which the varying sizes of CDs are taken into account. There is a fee for this service.

Below, we have described a simple method of obtaining a cluster sample which, however, ignores the fact that some CDs are bigger than others. ABS would select a cluster sample using a weighting technique that would take into account the relative sizes of CDs. However, we want to keep it simple, and the loss of accuracy is not so great that you would need to be concerned about a biased sample, unless you required an extremely high degree of accuracy.

Even if you are using the services of ABS, it is worthwhile reading through the following example so that you understand the general method of cluster sampling.

If you wanted a sample of 500 households out of 10,000 households in an Adelaide suburban area, you could obtain a cluster sample by following the steps below.

- From ABS obtain a list of all the CDs in the suburban area you have chosen, including the number of households in each CD.

- For this sample of 500, ABS recommends quite a small number of households selected in each CD - about six. You don’t have to be quite as exacting, and decide on ten. With ten households in each CD, you now need to select 50 CDs to get your sample size of 500.
- Randomly select 50 CDs (numbers in a hat, or systematically select from a list with a random start) from your total number of CDs.

- You now have to select the particular ten households in each of the 50 CDs you will survey. If there are 200 households in a particular CD, you divide 200 by 10 which equals 20. You will therefore have to visit every twentieth household in that CD. This calculation must be done for each of the 50 CDs.

- For each CD, randomly select a starting point by putting the names of the streets into a hat and selecting one. You now have a starting street. Now put all the numbers of that street into a hat (remember, a separate number for every unit, whether a house or a flat) and select one (you may have to wait until you reach the street to find out the number of households in that street). Start at this point and follow a random path (perhaps anti-clockwise around the block and then moving to the adjoining block and travelling anti-clockwise around that, etc) which takes you around the whole CD, stopping at every 20th house or flat.

**Other Ways of Selecting Samples**

In some situations, you may want to specify the size of sub-groups you want in your survey sample. For instance, in a survey of nursing home residents, you may want 20% men and 80% women because that represents the gender make-up of that nursing home.

Samples which contain a specified proportion of respondents in various sub-groups (e.g. sex, age, income) are called **stratified samples**.

**The Stratified Sample**

In a stratified sample, respondents are classified into subgroups with a specified number of respondents in each subgroup.

We will illustrate a stratified sample using the example of a nursing home where there is a population of 200 women and 50 men.

If you select a simple random sample of 100 residents, because the total number is so small, you may find that 85 of the respondents are women and 15 are men (if you toss a coin 100 times, it doesn’t necessarily come up 50:50).
Thus, if you wanted to reflect accurately the gender make-up of the nursing home, you could specify that the proportion of men to women in the sample had to be the same as in the whole population of the nursing home. In this case, you would select 80 women and 20 men (200:50 = 4:1 = 80:20). This would be known as a proportionate stratified sample.

In both the above cases (simple random sampling or proportionate stratified sampling), because of the greater number of women in the sample, the opinions of the women respondents would have a much greater weight than the opinions of the men. Consequently, the men’s needs may not achieve the same priority as the women’s needs. This of course may be acceptable, depending upon the aim of the survey.

However, we could get over the problem of the shortage of men respondents by specifying that the number of men and women in the sample had to be equal; i.e. 50 men and 50 women. This would be a disproportionate stratified sample.

To select this sample, we would require that names be drawn out of a hat (or selected randomly off a list) until there were 50 women and 50 men in the sample.

We strongly recommend that workers who do not have experience selecting samples consult the ABS Statistical Consultation Service to obtain assistance.

OOPS! My sample is skewed!

When a sample is ‘skewed’, it means that it is biased in a particular direction - i.e. not an accurate representation of the target population. Take the following example:

The Treeville Community Centre surveyed 350 residents of the suburb of Treeville to find out how satisfied or dissatisfied residents were with transport facilities in the area.

The survey showed that 69% of Treeville residents were quite satisfied with transport services. Comparing the composition of the sample with the composition of the population provided by ABS statistics, the research team found that although 50% of Treeville residents were over 50 years of age, people over 50 years of age accounted for 70% of the sample.
With this age distribution it was obvious to the health workers from the Centre that the survey results did not reflect the views of the overall population but were strongly biased towards the transport needs of the older members of the community.

What could the workers from the Treeville Community Health Centre do to make their survey results more representative?

- The results of the survey could be divided into age groups. The workers at the community health centre would then have information on how satisfactory transport services were to both older and younger residents.

- When samples are small, this procedure is not appropriate. In the above example, it would be tempting to divide the sample into two (or more) age groups. There would be 245 (70% of 350) people in the over-50 age group, but only 105 in the other one or two younger age groups - not a large enough sample on which to base confident statements about the younger age group.

- The workers at the community health centre could increase their sample size by adding more younger people to it. They could do this by using the same random selection criteria as they did to determine the basic sample, adding a screening question which, in the case of a household survey, requests the questionnaire be filled out by the youngest person in the household. Extending the survey in this way requires additional time and money, and its legitimacy is questionable as the members of the earlier sample may have different characteristics (other than age) from the latter sample. This is one possible method of getting out of trouble, but not the recommended one.

- A quicker option is to remove randomly a proportion of the older respondents from the sample to make the sample more representative of the actual population. This is advisable only if the original sample was larger than required.

- Perhaps the best option is that of 'weighting' the results. Most computer software capable of providing a statistical analysis of survey results can do 'weighting': each respondent's answer is valued down or up depending on, in the example given above, the age of the respondent. In the example above, older respondents' answers would be valued down and younger respondents' answers would be valued up. In this way, the oversampling of older people and the undersampling of younger people would be counteracted by the relative 'weights' given to their respective answers. Each
age group would then contribute to the survey results in proportion to their relative size in the population.

Don’t be put off by the apparent technicality of this procedure. This is the simplest, quickest and most common way of solving a problem with sampling maldistributions, and as long as the computer software you are using has a weighting option (and you know the age and sex composition of your target population!), it should be a simple matter for your computer operator to work out weighting values.

After weighting, the results might be written up like this:

```
In a sample of 350 Treeville residents (weighted for age), 54% reported they were satisfied with transport services in the area. Satisfaction was considerably higher amongst older than younger residents.
```

Weighting does have its dangers. When the smaller group is very small, peculiarities within that group will be magnified by the higher weighting given to each individual’s answer within the group. This can give the results an unacceptable bias.

One way of handling skewed data is simply to admit that your data are skewed and therefore not as accurate as they should be, and this must be taken into account in interpreting the data.

**Confused?**

You need not be. Use your common sense. When you are selecting a sample, ask yourself the following questions.

- How will it affect the information that I want from this survey if the sample contains more of one group than another; for example, more older than younger people, more women than men?
- How likely is it that I will get a larger representation from one particular group (elderly people are more likely to be at home) and less representation from other groups?

The answers to these questions should be part of your survey planning. They will help determine the size of your sample and how you select it.
CHAPTER 10 - SAMPLE SIZE

What Determines Sample Size?

When community workers plan to do a survey, one of their first concerns should be the size of the sample they need. In the real world, what usually happens is that we look at the funds available, determine the size of sample we can afford, and if this sample seems reasonable then we go ahead with the survey. However there is a limit to how far this approach can be taken. If your sample is too small, your results will have such a large range of error that they could not be taken as representative. This will affect how much you can generalise from the results.

When statisticians work out the size of a sample, they take into account a number of factors. These factors include such things as 'confidence level', 'error range', the population size, and also the expected results.

A Ready Reference to Sample Size

We have simplified the process by providing a chart which you can use to determine your sample size simply by knowing the size of your population. To do this, we have made certain statistical assumptions which are appropriate for this kind of research. Thus, the chart has been developed assuming a 95% level of confidence, a 5% error range and an expected response of 60% (see Kalton 1983). What this means, basically, is that you are expecting around 60% of your sample, or greater, to respond in a certain way to most questions in your questionnaire, and that you are 95% confident that the response you would have got if you had asked those questions of the whole population would fall within the range of 5% either side of the result you actually got from your sample.

For example, if you asked your sample:

‘Did you visit a doctor one or more times during the past twelve months?’

and 74% answered ‘Yes’, then you can be 95% confident that the result you would have got had you asked the whole population that question, would fall between 69% and 79%.
If, however, you asked the question:

‘Have you experienced any problems with diabetes?’

and only 8% answered ‘Yes’, then all you can be 95% confident about is that the proportion of people who have experienced problems with diabetes is somewhere between 3% and 13%, which is probably too indefinite to be useful.

The only way around this sort of problem is to increase the sample size so that the error range is reduced, say to 2%.

For example, for a population size of 5000, an error range of ±5% requires a sample of only 360, but for an error range of ±2%, a sample of 2000 would be required.

A result of 8% ±2% is probably accurate enough for the purpose of making decisions about a community health program, but it probably would not be accurate enough for epidemiological purposes.

If you think the response to a crucial question is going to be considerably less than 60%, as in the above example, and you are trying to decide whether or not to pursue a program for people who are in that minor category, then you will have to seek assistance from a statistician to help you to determine the size of the sample you will need. You may be able to obtain help from a statistician at a department of community medicine or primary health care at a large hospital near you, or at a psychology department of your local university, or (for a price) from the ABS.

**Determining Sample Size for Different Sized Populations**
For most types of community needs assessment, however, the Table we have provided is a useful rule of thumb for selecting sample size.

Thus, in the example below, we determine the sample size for a population of 5000.

Locate a population size of 5000 on the bottom axis of the graph. Draw a line vertically up from 5000 to the solid black line. From this point you draw a line horizontally across to the right hand axis to the recommended sample size, in this case, approximately 375.

**Do Refusals or Non-Responses Affect the Sample Size?**

Yes.

What happens when you send out 375 questionnaires and only 200 people reply? Well, then your sample isn’t big enough. When you select your sample, you have to have some idea what percentage of the people approached is likely to refuse to take part in your survey, and what percentage is likely to agree.

How do you estimate how many people are going to agree to take part in your survey?

- You can conduct a pilot survey using a small number of randomly selected respondents (selected the same way as you intend to select your main sample) and see how many agree to take part. You may find that 14 out of 20 people return questionnaires, i.e. 70% or 0.7. This is called the response rate.

- You can look at previous surveys of the same type to see what sort of response rate was obtained. Thus you might find out that similar surveys have obtained a response rate of 70% or 0.7.

To determine the number of people you should approach to obtain your required sample size, divide your required sample size by your estimated response rate:

\[
375 \div 0.7 = 535
\]

In this case you have estimated that you need to approach 535 people to obtain a sample size of 375.
To summarise, the number of people to be approached equals the required sample size divided by the estimated response rate.

Do Refusals Bias the Sample?

This depends on why your potential respondents refuse.

For instance, some people who were having trouble with a home budget may refuse to take part in a survey on the need for a budgeting advice service. In such a case, the survey results would be useless as the very people from whom information was needed had excluded themselves.

In most cases, the reasons people refuse have nothing to do with the survey itself. In the Marion, Brighton and Glenelg Community Health Needs Assessment, we contacted a sample of the people who had not returned the questionnaire to ask them why. Some had moved; others refused because they saw it as an invasion of their privacy; others couldn’t be bothered.

The important consideration is whether those people who refuse to do the survey are objecting to surveys in general or to the topic of your particular survey. In this latter case, you will need to re-think your approach and whether a survey is the best way to collect the information you need.

Non-response bias occurs when those who do not respond have different characteristics from those who do, and those characteristics could have some bearing on what we are measuring. Generally, we do not know the characteristics of those who refuse to take part in a survey, so the best policy is to endeavour to achieve a non-response level as low as possible.

Selecting a Sample Size

In our example in Chapter 9 of this Section, about a survey on the need for occasional child care, we used a sample of 50 to make a statement about a population of 1000. According to our chart, that sample was far too small to arrive at that conclusion. However, in that particular example, the aim of the survey was not to provide accurate data about the area, but to determine if there was a need for a service. To assess the need for services, surveys usually do not have to provide highly precise and statistically accurate answers. Your own judgement will have to be your best guide. However,
when funding allocation is involved, you are more likely to have to provide more accurate information.

Consider the following example:

A health worker in a community health centre wants to know what percentage of the population served by the centre has been diagnosed as having a high cholesterol level. An exhaustive search reveals that no existing information provides the answer.

The population of the area served by the health centre is 3,000. According to our chart, the sample size for a survey that will reflect the population at a 5% error range would be approximately 280.

In a pilot survey which approached 40 people, 35 people agreed to be interviewed: i.e. 35 divided by 40 = 0.875. The required sample size (280) divided by the response rate (0.875) = 320. Thus, to obtain a sample of 280, 320 people would have to be approached.

At this point, cost has to be considered. Has the Health Centre the resources to approach 320 people? The health workers may decide that 200 interviews is all they can afford. At this stage it is important that they look at the reason why they wanted the information - how accurate does it have to be?

What is the purpose of collecting the information? If it is to determine the need for a program, then 200 will give a fair indication of the need. If it is to report on the prevalence of cholesterol problems in the community, then 200 is not sufficient and it is time to rethink.

A word of warning. If you are writing up your results, unless you have a survey of an adequate size, you cannot claim that your results are a true reflection of the population, even though they may provide sufficient information for you to plan your programs.

A second word of warning. Samples are selected on the basis of finding out information about the total number of respondents. If you want to make statements about different sub-groups within your sample, you will have to make sure the sub-group is of sufficient size to make meaningful statements about it. If you know beforehand that you want quantitative information on a specific group within your sample, then work out your sample size based on this sub-group.
For example, if you want to know about the drinking habits of men and of women in a community of 2000, where women and men are in equal numbers, you would estimate a sample size for each sex category by looking up a population size of 1000 on the chart. This would tell you that you need 275, that is 275 men and 275 women, a total sample size of 550. This would allow you to make statements about both the men and the women with confidence. It would also allow you some latitude in making statements about other categories - for example, those determined on the basis of income or marital status.

OOPS! My Sample Size Is Too Small!

You've done a survey and you find your sample is not as large as it should be. What reliance, if any, can you place on your results?

- All information is useful and the information you have acquired may be quite valid. If the sample is very small, you may like to quote the raw numbers instead of percentages. Your information may not be able to tell you, for instance, that 70% of elderly people need podiatry, but if an overwhelming number of elderly people interviewed had untreated foot problems, then you can legitimately say this and conclude that there appears to be a need for podiatry services in the area.

- You could report the trends indicated by your data, noting that your sample was too small to make a quantitative statement.

- You could report your data with a larger error range. For example, you might like to indicate that instead of a 5% error range you have a 10% error range, and that your result could be as much as 10% above or below the result you would have obtained had you surveyed the whole population. To do this, you would have to know how to calculate sample sizes for various error ranges. As we haven't provided this technical information, you may not be able to work this out for yourself. However, a telephone call to the ABS Statistical Consultation Service would provide you with the information you need. If you tell ABS your sample size and population size, they will be able to tell you the error range of your data. They will probably want to ask you other questions as well - for instance, how you selected your sample - to determine how effectively you have carried out your research.
CHAPTER 11 - From Questionnaire to Analysis of Data

This chapter provides some guiding principles for translating the information you have gathered from a questionnaire into a form that can be entered onto a computer and then analysed.

There are a number of different techniques that can be used in moving from questionnaire to analysis; however, most follow the same procedures:

- setting up a coding guide;
- coding the information collected by the questionnaire;
- putting the information on to a computer;
- analysing the information.

Setting Up a Coding Guide

Coding guides basically provide a framework from which you can translate the information contained in completed questionnaires to numbers. The following diagram shows the coding guide for a question used in the Marion, Brighton and Glenelg Community Health Needs Assessment to prepare it for analysis using SPSS (PC) software.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Variable Name</th>
<th>Computer Line</th>
<th>Computer Column</th>
<th>Code</th>
</tr>
</thead>
</table>
| 10(a)           | Smoked regularly? | smokreg | 2 | 26 | 1 = Yes  
|                 |          |               |               |                 | 2 = No  
|                 |          |               |               |                 | 9 = Missing |
| 10(b)           | If yes - Currently? | smokcur | 2 | 27 | 1 = Yes  
|                 |          |               |               |                 | 2 = No  
|                 |          |               |               |                 | 9 = Missing |
| 10(c)           | How many per day? | cigs | 2 | 28-29 | Enter no. of cigs (01 - 98)  
|                 |          |               |               |                 | 99 = Missing |
Conventionally, data occupies 80 columns per line on the computer; when you have more data than this, then coding should continue onto the next line. The coding guide above tells the person coding the questionnaire that the information relating to question 10(a) should be placed in line 2 column 26.

The code column indicates to the person coding the questionnaire what number represents a particular response. The variable name, which should be no more than eight characters long, is used as a shorthand way of referring to the question on the computer. Full details of the coding conventions can be obtained in the manuals relating to the statistical software package you are using.

However, the questions in your questionnaire will not always be the simple tick-box type illustrated above; they may be open-ended, requiring the person completing the question to give more detail on a particular response, or to report impressions, perceptions or attitudes on a specific issue. If this is the case, responses will need to be assigned codes after the questionnaires have been returned by respondents.

In order to make decisions about which codes will be the most appropriate:

- select a sample of your returned questionnaires - 10% is usually adequate;
- review the responses given to the particular open-ended question you are coding;
- group the responses into common categories;
- assign numbers to these categories in the same way you would with tick-box type questions.

For example, in the Marion, Brighton and Glenelg Community Health Needs Assessment, respondents were asked what they considered to be the three best aspects for children and youth in their area. A multitude of responses were given, written in a variety of styles; for example:

- 'There are places for kids to play; playgrounds and the swimming pool.'
- 'The shops are pretty good - all you could want - and they aren’t very far away.'
- 'We’ve got beautiful beaches just down the road.'
However, after sifting through a 10% sample of the returned questionnaires, ten broad categories of responses emerged. The categories, and their assigned code numbers, appear below in the coding guide:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Variable Name</th>
<th>Computer Line</th>
<th>Computer Column</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>3 best aspects</td>
<td>best1</td>
<td>5</td>
<td>42-43</td>
<td>01 = Parks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>best2</td>
<td>5</td>
<td>44-45</td>
<td>02 = Schools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>best3</td>
<td>5</td>
<td>46-47</td>
<td>03 = Beach</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>04 = Recreation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>05 = Public transport</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>06 = Close to friend/families</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>07 = Close to facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>08 = Clean &amp; quiet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>09 = Close to health facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10 = Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99 = Missing</td>
</tr>
</tbody>
</table>

In this example also we assigned three variables (best1, best2 and best3) to the question, which ultimately treats the information as if it were asked three times (often referred to as a multiple-response question). The first best thing the respondent reports is coded in columns 42 and 43, the second in columns 44 and 45, and the third in columns 46 and 47.

During the course of coding, additional categories do occasionally emerge. As the coding guide above allows two columns for the question, new codes can be added. It is tempting, however, to keep adding codes; avoid this where possible by asking yourself whether the response can fit into an existing code - too many codes can make it difficult to analyse the information.
Coding the Information and Putting It onto a Computer

There are basically two options for coding that you can choose from: coding the information onto a coding sheet and then entering it onto the computer, or coding the information directly onto the computer.

The large amount of data produced by the Marion, Brighton and Glenelg Community Health Needs Assessment was written onto a coding sheet (such as the one displayed below) before it was entered onto a computer. This was mainly because coding was being done by several different coders and the data was going to be entered onto a computer outside the Research Unit. In addition, and perhaps more importantly, this method allowed checking of the coding by research staff before it was entered onto the computer.

If you have access to a computer and don't have large amounts of data, it is often more convenient and less time-consuming to enter the data directly. This of course also depends on whether you have appropriate software on your computer. There is an increasing number of computer software packages on the market that have been designed to accept direct data input, and include built-in editing functions that allow you to clean up or modify your data. One package in particular is Epi-info (public domain software), which allows you to set up your questionnaire, and do your coding and data entry, on screen. In addition, some data analysis software on the market (e.g. the latest version of SPSS/PC+) allows you to transfer data you may have stored on spreadsheet software.
Analysis

Most of the data you have on the computer will be analysed simply by using descriptive statistics (e.g. frequencies, percentages, means), such as in the extract below.

**SMOKERS IN THE MARION, BRIGHTON AND GLENELG COMMUNITY HEALTH NEEDS ASSESSMENT**

Just under half of the sample (46%) had smoked at some time and 23% were currently smoking. Of those currently smoking, 30% smoked 10 cigarettes or less per day; 41% smoked 11 to 20 per day, and 28% smoked more than 20 cigarettes per day.

How information of this sort can be reported diagrammatically is covered in some detail in Section 5 Chapter 1 - Reporting Back and Planning.

If you are considering analysing your data using some form of inferential statistics, for example, to test whether the differences you found between two or more sub-groups in your sample are statistically significant, you should consult a statistician for advice on the appropriate statistical test. One word of caution if you are considering doing some form of correlation analysis; **correlation does not necessarily imply causation.** For example, you may find that the frequency with which your respondents use public transport is highly correlated with how clean they rate the area in which they live. Despite finding an interesting relationship, it is difficult to say with any degree of certainty that cleaner areas cause people to use public transport more frequently (or vice versa).
qualitative research

Section Four
SECTION FOUR: Qualitative Research

1. Qualitative Research: An Overview
2. Participant Observation
3. In-depth Interviews
4. Group Techniques
5. An Example of Qualitative Research
This Section

The first chapter contains a discussion on the nature of, steps involved in, and some appropriate uses for, qualitative research, together with an overview of relevant practical and theoretical issues. Information on two computer programs suitable for analysing qualitative data is provided.

Notes on reliability and validity in qualitative research conclude this first chapter.

Chapters Two, Three and Four contain considerations of some commonly-used qualitative approaches: participant observation, in-depth interviews, and various group techniques. They are not intended to be exhaustive commentaries on these methods; nor do they represent all the important methods available. In the Annotated Bibliography of Section 6, references are included that describe other research methods.

Chapter Five illustrates one application of qualitative research from a SCHRU publication, ‘Measuring the Health of the City: A Glimpse of the Invisible Christie Downs’.

Discussion on analysis is concentrated in Chapter One, then within the subsequent chapters, it is related to each methodological approach.
CHAPTER 1 - Qualitative Research: An Overview

‘Current practice is unable to achieve some of... the objectives of health care research... because of its under-utilization of qualitative methodologies’ (Dingwall 1989:47).

Introduction: ‘Numbers Rule, OK?’

Numbers usually dominate our approach to, and understanding of, much in the health scene. Numbers can be used in many ways. They can reduce and simplify on the one hand, or they can confuse and mystify. However, community needs assessment is primarily about gaining understanding about the whole community, not just about those aspects which normally feature in health statistics. This type of needs assessment has the potential to transfer some power away from those people and organisations that have acted as the main ‘social interpreters’ of health and health care and who usually rely on quantitative research, to those who adopt an approach where social issues are seen as integral to health. It is there that social researchers can combine with ordinary folk to produce new understandings of health and health care, using a variety of research methods.

Quantitative, numerical approaches to research, and hence to knowledge, have been favoured over qualitative models, not only because of the limitations of the latter, but for complex social reasons to do with a dominant scientific culture and its powerful institutions protecting and serving their own interests, even when they purport to serve humanitarian ones (Acker et al.1983; Baum 1990; Lupton & Najman 1989). Other reasons concern the apparent need of our society for information amenable to computer analysis and our hunger for constantly-changing ‘newsworthy’ events - statistics make it easy to tell sharp, shiny stories.

In the health arena, there is a growing recognition that statistical analysis is often based upon a limited understanding of how humans think, talk, and decide about health-related matters, of how they live out their lives day-by-day with behaviours and social settings which may affect their health and well-being.
This is not to wave a banner of slogans down-grading quantitative research, or even to infer that qualitative research is inherently ‘better’. In preceding Sections, we have seen that quantitatively-oriented work will remain important to most aspects of health-related endeavour. It is important to keep in mind that both approaches have their advantages and limitations (Fielding & Fielding 1986:91).

However, because the power-base does remain firmly within the quantitative camp, those who would advocate a shift toward a better balance of quantitative and qualitative approaches should bear in mind how critical it is for non-numerically based research to be good research. If such research is to have an impact, then it should be related to theory, and be conducted in a rigorous and systematic manner. We should also be aware that our (minimally statistical) research will have to find a place in a highly politicised health arena where ‘numbers rule, OK?’ Many worthwhile projects have lost the battle to achieve government funding because they got branded ‘unprofessional’, ‘hazy’, ‘too subjective’ and even ‘unscientific’ (Wadsworth 1984:79). Such criticism may have been, in part at least, justified, but it also demonstrates the inability of many funding authorities to handle projects that don’t fit their narrow, and often theoretically suspect, assumptions about research.

What is Qualitative Research?

Qualitative research in one sense is a bit like massage. When did you last rub your cheeks? . . . not long ago probably. Everyone does. massage, even if subconsciously, but a masseuse who has studied and practised it should do it better, and would no doubt also apply it in ways (and places) we may not even have thought about. Every day of our lives, we make many decisions on a range of matters. In effect, we weigh up many things, or ‘factors’ as they can be called. Hundreds, if not thousands, of factors make up our personal understanding at any time.

Everyone Does Qualitative Research

Without consciously reflecting on our own thinking, which constantly assesses a range of information, we often decide upon a particular view of something, at least tentatively. Let us call this ‘view of something’ that we have arrived at, our ‘concept’. If we discover more information that seems to challenge the adequacy of our concept, that is, if it does not quite ‘fit’ the new information, we can modify our concept. Using this new view that we have arrived at, more information is assessed - again, to see if it is appropriately
explained or described by our modified concept. This may be done at lightning speed in our thinking, or it can be a painstaking pencil-and-paper task, depending upon the decision and the type of information. The important thing is that we all do it: there is nothing mysterious about the way we change our thinking on things.

Checking Our Prejudices

To illustrate the above process, uninformed people may have arrived at the view that all black people are lazy and drink too much. This view may have been determined mostly by earlier experiences such as the prejudices of our home and school environments.

Such views also may have been reinforced as they witnessed the behaviour of a few black people at the town square or near an employment agency. However, with further experience, including, say a chance meeting with a black person in totally different social circumstances, they may have been tempted to reconsider their former view that all black people are lazy and drink too much. That initial view of black people, if those people were to stop and think about it, may have changed; the likelihood of ‘all black people being lazy’ let alone ‘drunkards’ would have begun to look rather shaky.

Now let us put ourselves into the shoes of this once racist person: upon realising that we had once possessed a view of health-related behaviour of black people that was highly suspect, we may delve deeper even among black people who do drink a lot to attempt to learn why they behave that way. Then if we were thinking systematically, we may realise that we have not included non-black people in our thinking much at all; we may see the need to explore, say, the drinking behaviour of non-black people at football or cricket grounds, or on beaches. Such a change in our point of view may have happened in a rather random manner in our thinking as we matured over a long period, or it may have been the subject of intensive scrutiny over a brief period. In either case, we would have been in the process of theory-building and theory-modification.

Theory Building and Theory Modification

All of us, sometimes haphazardly, sometimes systematically, confront complex information which leads us to reconsider former ideas, and we don’t just test former viewpoints to see if they fit in a ‘Yes’ or ‘No’ fashion, but we build further ideas as needed, in order to strengthen the likelihood that our (new) viewpoint fits all the information available to us.
In due course, new information may become available to us and we may have to reconsider our ideas yet again. This is the process that lies at the heart of qualitative research.

Qualitative researchers, such as ethnographers or anthropologists, have merely developed this common procedure for dealing with primarily non-numeric information into a systematic research method.

The ultimate aim of all research, regardless of approach, is to arrive at conclusions (i.e. generalisations) that hold true considering all the relevant data. In qualitative research, without this systematic process of idea or theory building, in which our data is checked and re-checked and our ideas modified (the process known as the logic of analytic induction), qualitative researchers are left with a serious dilemma. Our conclusions could be disregarded as merely chance or convenience conclusions, with little power to persuade others.

We should recall briefly, although this will be developed later, that this ‘validating’ process is fundamental to all research. ‘Experimenters’ can use control groups; ‘survey researchers’ can use statistical tests of significance to assess the explanatory power of different variables’ (Silverman 1985:111-112); but ethnographers or field researchers wage an uphill battle of considerable scale if they do not use important (equivalent) analytic aids: in other words, aids to the process of modifying and testing theories in order to produce more appropriate and soundly-based theories or generalisations. One significant aid is the process of deliberately searching for data which appear to refute our tentative conclusions, which may then lead to modifications of those conclusions.

Needs assessment in community health usually involves the application of qualitative research techniques to community health issues, and there is much to learn from those who have been involved in the process (see Section 6).

The ‘Navel-Gazers’ Versus The ‘Number-Cruncheers’

The Qualitative Basis of Quantitative Research

Confusion and simplistic assumptions cloud the question of differences between ‘qualitative’ and ‘quantitative’ research - differences which mark a division that ‘is entrenched in the core disciplines of social science’ (Fielding & Fielding 1986: 10). In exploring these differences, the first point to emphasise is that they
each share problems common to all social research, and they are not firmly separated at opposite ends of the 'smorgasbord' table of which we have spoken in Chapter 3 of Section 1. In fact, one cannot embark upon quantitatively-oriented research without a considerable use of, and attention to, qualitative aspects.

Quantitatively-oriented research, in so far as it manages to grasp social life with integrity and validity, must utilise qualitative factors from the first moments of research design. It must do so in the process which brings into being a specific questionnaire and, for example in those decisions about which words to choose or how questions should be phrased; when an interviewer seeks clarification of an answer to a quantified question; in the theoretical assumptions that underlie statistical procedures and through which data are interpreted (Shaw & Miles 1979); and in those decisions made in the corridors which are vital to the research process itself (Becker 1965; Bell & Encel 1978). Fielding and Fielding (1986:12) believe that 'ultimately all methods of data collection are analysed “qualitatively”.'

It is not exaggerating then, to state that a ‘good’ quantitative, statistical research project depends upon good qualitative research to inform and shape the entire project. When we speak of the differences between these approaches, therefore, we are merely talking about the extremes. The implication of this is that a lie is being sold in the research market place. Quantitative research is really an ideal type - it does not exist in pure form. All research is qualitative to a significant degree.
In Section 3, we have seen how survey research utilises primarily quantitative approaches, and concerns itself with numbers, their meaning, and their analysis. These can be important in the design and conduct of some qualitative research projects. But in order to understand the differences between qualitative and quantitative approaches, and when to use qualitative methods, we have to discuss some of the limitations of survey research methods.

Why Use Qualitative Methods

As we have seen in the ‘Smorgasbord of Methods’, we choose our methods primarily after deciding what our overall purpose is - not the other way around.

Let us say then, that our overall objective is to explore relatively new research ground, that is, the health of a special sub-group of a population, say young adults in rural towns, with particular attention to substance abuse, lifestyle and social environment. We have made that decision after discovering: a) the lack of information about the issues we wish to cover; or b) that such information has been based upon inadequate data and hence has not been rigorously considered anyway; or c) that such information (for instance from a survey) provided good background understanding but did not attempt to provide the depth we are seeking.

So, survey research methods using pre-determined categories and questions, as in structured questionnaires, may be inappropriate, as they would hinder co-operation and limit the range of information likely to be generated, particularly if our research topic involves sensitive issues like substance abuse or sexual abuse. Such qualitative methods as informal interviews combined with observation are more likely to be successful. Furthermore, our more specific aim may not be so much to test assumptions or hypotheses by building them into a rigid research design, but to generate them and, generally speaking, qualitative methods are best suited for generating hypotheses (see Figure 2 in Chapter 1 of Section 3 for how to go about deciding whether survey research methods or qualitative methods are appropriate for your purposes, and Figure 3, this chapter, for a summary of the processes involved in theory testing and theory generating through quantitative and qualitative methods).

What is Qualitative Data?

To say that qualitative data differ from quantitative data, because the latter can be counted, is too trivial a difference. There is no ‘quantitative world’ and no ‘qualitative world’. From the survey
research tradition where 'numbers rule', qualitative data includes everything not expressed in mathematical or statistical form. However, as Ditton and Williams have put it, 'Qualitative data is not somehow incomplete quantitative data... [It is] authentic data in its own right' (cited in Halfpenny 1979:803).

Qualitative research involves 'grasping the meanings through which the people under study conduct their social interactions' (ibid:809) and so far as any social data does this, it must be qualitative, according to the research tradition where 'meanings' rule (ibid:819). It is not simply the 'first step in the measurement process leading on to the construction and test of explanatory hypotheses... [it lies] at the very core of the explanatory enterprise' (ibid:809).

In needs assessment, qualitative data is usually text (field notes) but it may also consist of films and ideas, drawings or even photographs.

**The How and Why Questions**

The most important distinguishing feature of qualitative approaches include their suitability for probing the 'how' and the 'why' questions of human behaviour at a deeper level - and frequently they are the only tools to use for exploring behaviour in everyday social settings. A recent research project will illustrate one of the limitations of quantification in exploring the 'how' and 'why'.

Aboriginal and non-Aboriginal single parents' perceptions of past partners were probed in the context of a comparative study exploring social and health issues of urban Aboriginal households. This question was put to each, and interviewers had to decide on one of the categories to describe the respondents' perceptions:

'Overall, how did you get on with your [spouse or de facto] partner(s)?'

1 = Very Badly    2 = Badly    3 = Quite Well    4 = Very Well

This question is an example of a quantitative approach to a qualitative (or a highly subjective) matter. Sometimes respondents could not choose only one number to represent their perceptions of past experiences, because they had been through a range of experiences with one partner, or with multiple partners. To illustrate, one respondent's past relationship was felt to have been positive overall, but it ended as the male partner allegedly became violent when overly influenced by alcohol. Another respondent had had four partners, two of whom she regarded as good, and two of
whom she regarded as terrible. Hence the interviewers in those cases had to force the responses to fit a more-or-less appropriate box. It seemed that the more the interviewers sought a decision one way or the other, the less likely it was for the subsequent answers to be meaningful. Clearly this quantified, closed part of the question yielded an inadequate and misleading summation of complex past experiences, which were elaborated in subsequent discussions - during in-depth interviews.

On the other hand, it was appropriate and helpful to quantify perceptions of other past experiences, such as sexual assault or self-destructive behaviour incidences, but on one condition. The questionnaire coder had to be a researcher, and not merely a data-entry person, as conceptual coding was frequently required due to the manner in which many respondents offered non-numeric ways to describe past experiences. Also, interviewers had been instructed to record such descriptions if the respondents did not feel comfortable with numerical responses, such as ‘more than ten but too many times to recall’ in answer to ‘how many times physically assaulted’?’. This distinction between categorical coding and conceptual coding is a vital consideration for any project investigating controversial and/or sensitive topics, that mixes closed questions (categories) and open-ended questions (concepts, perceptions, etc.) (Labaw 1985:138-139).

Thus it is often impossible to adopt a simplistic either-quantitative-or-qualitative approach when investigating sensitive matters of considerable community health consequence. The research design, therefore, should be balanced to give full recognition of this factor.

Another Example: Researching ‘Disability’

As we have seen in earlier Sections, counting is important in helping us gain some appreciation of the extent of a health problem in a social group or population: for example, how many parents or care-givers (per thousand of population) have a child who is severely disabled? But numbers tell us very little about the intimate daily lives of those care-givers, as they attempt to manage their disabled children.

To develop our consideration of disability, what can qualitative approaches offer us if we want to investigate family management of childrens’ disabilities? Analysis might concern such questions as how they both practically and intellectually deal with disability and all its complex consequences. We might discover, for instance, that they view gross disability as a sign that the ‘Great Spirit’ is punishing them; religious and belief systems may be vital in such cases and we should not assume that such ideas are only
characteristic of black or ethnic people. And how do these care-givers feel they are coping? What do they mean by ‘coping’? Are there ways community attitudes and services can help them? Do they need help at all, as we may be assuming? How do they regard ‘help’? Thus we begin to explore the kinds of matters that can be researched more profitably using qualitative approaches - and the kinds of special challenges they present!

Qualitative research, then, tries to investigate all manner of things about human behaviour that cannot be described adequately through statistical processes. On the other hand, quantification may still be used as an adjunct to qualitatively-oriented research (for example, in counting how many times a certain behaviour takes place).

Limited Application of Standard Questionnaires

In an attempt to build ‘universal’ understandings of psychological attributes, psychologists have developed a battery of complex and lengthy ‘standard’ questionnaires, designed to plumb the depths of personality and emotional states. However, their use in community health research, and thus outside therapeutic and clinical settings, remains controversial and fraught with theoretical problems, especially in cross-cultural environments (see Badcock and Ross 1982).

Nevertheless, such standard schedules can be used or adapted for needs assessments when not used in isolation, and when particular care is directed to possible differing cultural interpretations of questions and categories. (The use by the SCHRU of the Nottingham Health Profile in the Marion, Brighton, and Glenelg studies is mentioned in Section 1 Chapter 4). One particular advantage of standard schedules is that they provide opportunities for comparison with other researchers’ published results. They and the comparisons they facilitate, however, never yield ‘the whole truth’. Meanings attached to categories can vary significantly, not only for respondents of different cultures, but also for those of the same culture.

Other Advantages of Qualitative Methods

Other important and connected advantages of qualitative methods include:

- the people involved in the research and who are under investigation play a greater role in defining what is important and why as the research process is a co-operative one utilising the insights of the community (Najman
Although good quantitative research is built upon prior qualitative explorations of variables (for example, qualitative methods are frequently used in the pilot stages of survey research precisely to help ascertain the most important issues), nevertheless survey research methods ultimately remain bound to the researcher's prior determinations of the categories to be used in exploring particular issues.

- It follows that researchers have greater freedom as they are not bound by rigid data-gathering techniques and/or hypotheses that predetermine the entire project (Denzin 1970:216 in Silverman 1985). They can follow events as they unfold, and opportunities can be left open even for longitudinal study of actions and attitudes. Also, some would argue that this is the most legitimate manner in which causation (the causes of things) can be explored (Najman 1989). This is impossible in a strictly one-off, cross-sectional survey, but before-and-after cross-sectional surveys may also purport to reveal trends over time.

**Other Possible Qualitative Research Agendas**

Qualitative methods can help fill a substantial gap in our understanding and evaluation of health and health care - a gap which is the result of the domination of the health research agenda by utilitarian approaches to social investigation solely reliant upon statistical analysis (Baum & Brown 1989; Dingwall 1989:47; Silverman 1989). This is not to supplant quantitative methods such as epidemiology, but to ‘take account of complexity, open-endedness, multiple interactions, value choices, social rules’, and so on, that affect health in the dynamics of social life, as Brown has emphasised (cited in Baum and Brown 1989:143).

For example, qualitative methods have the capacity to help us explore beyond the structure and the outcomes of health service delivery (i.e. ‘performance indicators’), to the ‘process’ (Dingwall 1989:47). This suggests the need for more studies focussing upon the investigation of the ‘inner engine rooms’ of the various levels of health system operation and perpetuation: the board rooms as well as the surgeries, the hospital corridors as well as the wards, the community centres as well as the local playgrounds, the factories and beaches as well as the clinics, the ‘merchandise display seminars’ for supermarket managers, as well as the food choices of the consumers. Creative ways of linking analysis of regional health expenditure with comparative regional studies of health may also be appropriate - for example, in country areas. The intra- and inter-family context of health, and the wider social interactions in which
health is discussed and decisions made, are research areas vital to health promotion campaigns and to considerations of interactions between health-professionals and clients. For some examples, see Chapter 5 in Fletcher 1974 (an observational study in a hospital), and Richards 1990 (a qualitative study of suburban life in Melbourne); for an intensive study of the family context of children’s health, see Blecke 1990; for discussion of family health research and qualitative methods, see Pill 1988.

In terms of assessing needs, qualitative research can be particularly useful to assist with innovative, lateral thinking. The scope for simply confirming current practice is probably less when detailed investigative methods are used. Research areas such as these are being expanded through the use of qualitative approaches, such as participant observation, in-depth interviews and focus-group methods (see Chapters 2, 3 and 4). In South Australia, the Social Health Atlas provides many opportunities for qualitative research in specific localities; one of which may be to shed light on ‘anomalies’ in the data - for example, where unusually high levels of respiratory-related morbidity are indicated in affluent areas.

It has also been noted that even in the literature on the ‘new public health’ or sociology of health, theoretical and methodological problems in some studies have prevented adequate exploration of cultural or behavioural explanations of illness (Powles & Salzberg 1989).

All of the above, we hope, serves to encourage further innovative, qualitatively-oriented research to test and explore current assumptions, particularly with regard to cultural explanations and health, or the lack of them. In addition, Dingwall has reminded us that one important focus frequently lacking in health service evaluation, is the ‘humanity’ of the service (Dingwall 1989:47). When conducting needs assessment, it is important to ensure that the humanity of services (caring attention to human needs) remains a prime consideration in contrast with the planners in this Manual’s companion video, Best Laid Plans . . .

Values, Attitudes and Outlooks

Because qualitative techniques probe deeper levels of human experience, (for instance, those that expose feelings, beliefs, values, and attitudes), we not only encounter various ‘community’ attitudes in the field in which we are working, but, if we care to admit it, also our own, as researchers. Our values inform everything we do.
Because we are citizens in the same society in which we are carrying out this research, and likewise are products of that society, we are unable to disentangle ourselves from many hidden assumptions that are simply part of our own personal make-up, and no less so if we have been trained in social research.

Common sense, if we think about it, also is a creation of our society. It is constantly being infused with new ideas and so is socially determined and theory-laden (Giddens 1989). Even everyday research terms like ‘socio-economic status’ are steeped in social assumptions (Barnes 1990).

‘Horrible, Hairy Spiders’ - and Us

We all hold certain things dear to us; not just matters of common sense but also of morality and lifestyle. We possess a personal and cultural outlook that incorporates understanding about this thing called ‘research’, what it may be able to achieve, and how various client/respondent groups will regard it and us. We possess ideas about society generally: what makes a good one, how we feel in this one, what seems to hold it together, and what seems to create changes within it. All of these tangled, cobweb-like, fragments of our world-view contribute to the theoretical considerations of social research and, as Julienne Ford (1975:142) reminds us, we must acknowledge the ‘horrible hairy spiders’ that lurk within our frames of reference and our potted theories.

In observing a community health centre, for example, are there people or particular kinds of people that we would not feel comfortable being fairly close to for an extended period, particularly for in-depth interviews? Do we care more about the opinions of some people than of others?

Whether or not we wish to discuss these issues, and whether or not we want to admit it, our research will reflect who we are socially and culturally, both in its methodology and, inevitably, in its results. We cannot divorce our personal and cultural ‘baggage’ from our interactions with other human beings, their ideas, and our perceptions of their ways of behaving. Thus a certain type of person, organisation or institution is more likely to choose one way of looking at social reality than another way.

Observing Ourselves as Well

But our methods and our topics reflect not only who we are (education, age, gender, and so on), they also affect the people or
organisations being researched. Since the 1950s, some social scientists have realised this important factor. As Adams and Preiss (1960:3) have stated (our emphasis):

field workers . . . cannot avoid playing a role in the field situation. The question is not how to avoid affecting behaviour of the people being studied, but how to control and judge the quantity and quality of that effect. The question of research relations, in short, is just as much a part of field technique as that of constructing a questionnaire . . . or making a map.

This applies to all research, but to qualitative research in particular.

It follows that our research would be enhanced if we became more aware of our own values, attitudes, and thinking, and how they shape our research. In becoming more observant of ourselves, we would become better observers of others. People in the community who are part of the research also possess socially-determined views and complex feelings on a range of matters. Or they may possess strong ideas and attitudes on only a few issues, perhaps just as we do.

As we consider further the data being generated by our methods, we may be forced to question the truthfulness of what is being revealed to us as researchers. We cannot accept simply at face-value what we are told and what we see. There may be no right or wrong answers on many issues. The task may often be to understand how the answers we are being given may be influenced by, or indeed be a product of, wider realities such as the respondents' social position (status), and social power (which some call 'class' - see Connell 1988 for a discussion on health and class) and even by the fact that respondents may be using the research opportunity to achieve something for themselves.

In any case, the particular setting in which this data-generating life event is located will impose its own meaning on what is being revealed, and details concerning it must be recorded along with respondents' comments. The implications of all of these theoretical issues are considerable, as Richards (1990:x) indicates in the introduction to her quantitative and qualitative study of suburbia:

Data are constructed in interaction between researchers and researched, and keep changing. Researchers can extract few unchanging objective 'truths' from a studied setting (and the available ones are generally uninteresting). Their task is to do their best to understand and keep on interpreting what is going on and the meanings people put on socially constructed reality.
Needs assessment is no different to other social research. We should aim to get behind the clichés and normative needs statements (Bradshaw 1972), to those needs that are unexpressed and less expected than an initial study usually reveals.

**Face Value, or Reading between the Lines**

Qualitative approaches to research probe people in various social settings. Inevitably, this necessitates interpretation of what they say; that is, words are not enough. Are they using sarcasm, for instance? Hence we need to note their gestures, voice inflections, tone of voice and mannerisms in order to explore meanings. Without attempting to 'read' them, we can misconstrue important social events. It is clear, then, that our interpretation must form part of our data.

Participant observation is concerned with this detailed type of research. We must be sceptical of how much we can really know (that is, know for sure) about the situation we are investigating, and realise that it is not likely to be as straight-forward as it seems at first.

If we bear in mind throughout any project that interpretations are critical, we also stand a much better chance of making reasonable claims rather than outrageous ones, and of producing an interesting and useful result that is more likely to be acted upon in practical ways. We cannot and should not avoid incorporating our interpretations into our data, as they can enhance our understanding and therefore our chances of influencing change in those areas we care so much about, and which may have involved us in research in the first place. The more we openly incorporate personal interpretations, though, the more convincing our arguments must be in support of later generalisations.

**Journalism or Rigorous Social Research?**

Approaches to research can vary from good investigative journalism, examples of which we may see in a *Four Corners* program, to systematic and rigorous sociological and anthropological analysis (Rose 1982:111), which may be concerned with testing or generating specific theories about society, the way individuals behave and, for instance, the social causes of illness. Most community health research will fall somewhere between journalism and rigorous social research. We will often not have the time or resources to be as rigorous or as concerned with theory building and testing as social scientists. Hopefully, however, we will
have a stronger theoretical basis to our work than do journalists. Don't be frightened by theory. All research has theoretical implications. In practical terms, it means that we have a framework within which to collect data, make sense of it, and report it in a way that can be understood and translated into action.

Principles of Qualitative Research

No matter what techniques or perspectives are chosen, the following principles of qualitative research should be considered (primarily adapted from Silverman 1985:18-25).

- Regardless of the long-standing rejection by some physical scientists, of social science as a science, 'it is also an increasingly accepted view ... that work becomes scientific by adopting methods of study appropriate to the data at hand', or to the topic under investigation. Choice of methods is therefore critical.

- Obtaining an 'insider' view of life (especially of those who are regarded as underdogs of society), is not without some dangers, not the least of which is reliance upon key informants who may, or may not, be sufficiently 'inside' to provide reliable information. Informants are easy to find but hard to trust. In addition, learning about what it's like being oppressed and exploited, for example, may be quite different from learning about the social and economic structures and ideologies that keep people in that state, and some would argue that only those that have experienced real hardship can understand others in that state.

- Time, and the passing of time, is critical for many research projects because, 'attitudes and behaviour are revealed in process ... rather than being fixed to a particular role'. Through observations conducted over a period of time, we can hope to arrive at some understanding of the dynamics of social relationships. This highlights the need to take your time to form impressions and conclusions.

- Action makes sense in context. The implication of this is that, for instance, behaviour and talk in one setting should not be seen as undercutting what appears to happen in another setting. How it makes sense is what matters most. Therefore we are not primarily setting out to judge the truth, but to understand opinions, expressions of feeling, etc. in their various settings.

- Following the above point, we have to be careful about inferring a master 'reality' in terms of which all accounts and
actions are to be judged... Putting the picture together is more problematic.'

- In order for research to be critical, we should 'seek constantly to identify and to account for deviant cases'. That is, those cases which appear not to fit the emerging themes must be used to reconsider those tentative themes.

- Flexibility is necessary for a viable research design. 'Inevitably, in much mainly qualitative research, the research problem will undergo several re-specifications during the period of study.'

Researchers need to be careful not to impose their own ideas of what they expect to find in the field; they could actually bring about significant effects which are not normally present in the situation being studied.

So, having established some of the principles of qualitative approaches to research, let us turn to the doing.

**Doing Qualitative Research**

**Analysing Existing Material**

The first task is to find out as much as we can about the topic being investigated. We need to gather social and economic data available from libraries, archives, public records offices: Local, State and Federal government departments. Some regions also have local history museums which may hold useful material. Such material may comprise documents, film, video, tape recordings and so on.

These data form an important supplement to qualitative information emerging from field research. Or it may well be that a great deal of information is already available on many issues, and we may only add to it on a particular aspect, say to test or to enhance an argument we can make using existing material. If we ignore existing material, we may be wasting resources by 're-inventing the wheel', or our analysis may be superficial and unbalanced.

**Consulting Other Information Providers**

The kinds of people who may provide us with further information depends upon the research approach we have chosen and the topic under study. Obviously such persons must be able and willing to talk about themselves - their feelings and aspirations - rather than just providing one-word answers. Health workers familiar with
their local area may have no difficulty in seeking out knowledgeable people. In a small community, the reputation of a person as a reliable and candid source of information is probably fairly well-known, or at least easy to find out. However, all researchers should beware of talking only to those groups and individuals with whom they are familiar and feel most comfortable. The least articulate are the most frequently ignored in much research.

Having sifted through existing information and talked to key people, we should be able to identify and write down in simple, clear terms: a) the main concepts being used and b) the major generalisations that have been developed. We should apply this step no matter how simple or how complex the topics may be.

Our fieldwork will then aim to explore these issues and/or, at least partially, provide opportunities for comparison with the generally-held views we have discovered. The matter of comparison is very important as Dingwall (1989:48) indicates:

*The comparative method is central to all field studies, whether it takes the form of a deliberate sampling of research sites in order to make a critical testing possible or the use of existing literature as a background to single case studies. The one-off ethnography conceived and executed in magnificent isolation has no place in modern social science.*

However, the question of what such a comparison yields requires elaboration, and this is done briefly in a later discussion on the matter of generalisation.

**Collecting Data: Introductory Remarks**

Fieldwork refers not only to the actual collection of information (remembering that collection involves values and our theoretical framework), but also to the building of rapport with people - getting to know them socially, and hopefully earning some trust. This of course depends to what degree our project is 'research-with' rather than 'research-upon' those who are providing information. Mostly it should be the former. Sharing the purpose of the project with as many people as possible is therefore essential.

For community health workers, fieldwork can be an extension of their work in the community. Needs assessment research can build on and extend the understanding gained through their work with health centre clients. Moreover, researchers may be able to identify key figures and dominant political relationships, and to gain a deeper understanding of the power-brokers in the community,
some of whom may later be interviewed in depth. One outcome may be that community services are seen from different socio-cultural perspectives.

‘Gaining an inside view’ is one main aim, and this involves attempting to understand social life from the perspective of the information providers. Ideally, this should increase the usefulness and validity of the information we are hoping to provide about the local community. However, this is not as straight-forward as it sounds; nor does it guarantee a sound research outcome, as Adams & Preiss (1960:vii) have reminded us: ‘The field situation is one in which the student, “prepared” by ... undergraduate training, goes forth to find [him/her] self unprepared’.

Many researchers have been led to believe certain things about certain people or groups while attempting to reach the goal of ‘inside knowledge’, only to be later ridiculed (or worse) by those with whom they had lived and worked. A common mistake is to assume that there is a single, true opinion on any given topic. We should never assume that this assumption is anything but risky, and we should be alert to any tendency to summarise and generalise too early.
As we are researching with a particular community or group, we should seek their reactions to our tentative findings long before publicly releasing them. There is considerable value in having established a steering committee which represents many of the key groups in the community, especially at the various points where feedback is vital in setting the agenda for the next stage of the research.

Of course, gaining feedback from many individuals who live in one geographic community, yet who hold diverse views, may not provide what we were looking for, that is, assurance in relation to our findings. There is little likelihood that everyone is going to agree with all of our conclusions anyway. This is something that we just have to learn to live with - as long as we have made a genuine effort to allow discussion of our results with representative groups. This important matter is also considered in the final section of this chapter.

Developing Explanations

Analysis is not merely something that is embarked upon at the conclusion of fieldwork. Rather, it is an on-going process commencing from the moment a research project is formulated. For example, we will have already considered analysis of the data during the process of designing a questionnaire (Section 3 Chapters 7 and 8). Note-taking is essential to fieldwork, and our notes will contain our analytical and theoretical ideas which also form part of our data.

a) Analysis: Some Initial Approaches

Analysis of field data requires more discussion than can be accommodated in this Manual; nevertheless, as it remains one of the most difficult matters about which we can readily find sufficient or accessible material, we will explore its main features.

The primary aim of our research is to identify the problems faced by communities and individuals in maintaining and promoting health - What affects people's health? How is health sustained in the community? What does 'health' mean? and so on.

To do this requires the analysis of our field notes (see Bailey 1978:229-230 for one approach to this). Not only should we be comparing items in our field notes but we should also be comparing our field notes with other material we have read and other field experiences and interviews. Thus, we are performing numerous comparisons, which form the fabric of explanation (Fielding & Fielding 1986:16). As our notes and transcriptions from tapes will
be a combination of our own analytical thoughts and comments, and those of our informants as we have recalled them, we must ensure that these are not clumsily intermingled. In brief, field notes should contain:

- the name of the person/interviewee, the situation and the date;
- the issues raised and explanations given;
- our own analytical comments;
- a summary of our impressions of the data; and
- ideas for follow-up.

So our records probably contain hunches concerning meanings in the data and personal assessments of our own impact on the people we have encountered. These are of utmost importance, but methods textbooks are often silent on this (Richards & Richards 1990b).

We should reconsider to what degree our perceptions and interpretations may have been influenced by our preconceptions. Did we let some evident theme become a pet concern that in turn coloured our interpretation of other events and other sub-themes? Was that experience we were involved in, fully or only partly explained by our emerging theme? What actually happened in that observed event or in that interview? Can we substantiate that? To what degree? Was it adequately noted? Can we readily identify respondents’ comments that support emerging hypotheses? Did we describe those key events in sufficient detail? Do others agree with our recognition of these ‘emerging themes’?

Perhaps at this point we need to step back from our data and reflect upon how we arrive at a conviction that certain events or experiences or data actually relate to the tentative themes or ‘hunches’ we may hold, or to the concepts that make up those ideas? What evidence have we, for example, that those in rented government accommodation experience greater isolation? How do we develop that argument? What steps do we take to link our data and the tentative theory we wish to put forward? The strength of these links determine the quality of our entire analysis.

b) Categories, Labels and Theory-building

During this secondary reading of our notes and transcripts, we must begin the process of labelling significant categories of data. These categories then become the basis for building classifications and for perceiving the connections among them. The importance of this
process cannot be over emphasised: ‘the quality of this work will affect the quality of all analytic work erected on these premises’ (Fielding & Fielding 1986:15).

We apply these categories or labels to the persons or situations being studied in order to make the data manageable, and to name meaningful social phenomena. With new computer software which will be discussed shortly, we have greater freedom to explore not only those labels which describe our data but also the subtle and complex ideas that lend meaning to less obvious themes in the data - and to search, sort and test them speedily with our data.

We may for example, identify ‘independence’ as a theme, and such categories as ‘independent older people’, ‘semi-independent older people’, and ‘reliant older people’, at least to begin with. Later we may need to group these categories into sets of categories, such as ‘older people versus younger people’. However, these categories or sets do not necessarily leap off the pages of our scrumpled field notes to declare themselves. We, the researchers, bring them into being. But they should remain grounded in our data (Glaser & Strauss 1967). That is, they should be concepts that have been suggested by the data as we reflected on our field experience and our former analyses of existing material.

Thus the final stage of data analysis in field studies consists of using field notes, and those categories and sets of categories we have created, to build theories. Along the way, it may be appropriate to devise flowcharts. Flowcharts can be constructed in many ways. For a project using participant observation, the following simplified version could describe the observed, patterned behaviour of a small gang of young people on Saturday nights:

```
meet at Chook’s place —— pile into one car —— to pub till closing
|‘getting smashed’

< city centre
|‘hanging around’ —— decide who to stir up ——

|if fight looks likely
|scatter and meet at secret location

|if fight doesn’t look likely

|to Chook’s place
```
Such a flowchart may represent one of many by the time all relevant data on a given topic have been assembled.

c) **Theory Testing**

The next task is to attempt to fit all relevant cases to each of the possible explanations until a ‘best fit’ is achieved. In needs assessment, our goal is to identify what we believe are significant health-related problems in the community; we may also be able to develop a general theory which can be tested by further research elsewhere.

An important testing process involves deliberately attempting to find data that refutes each explanation. In practice this means searching for cases in our data that deviate from the majority and hence challenge our tentative theories. If an explanation is refuted - i.e. some of our data contradicts it - a new theory or explanation, which is a modification of the original, may be suggested. This is then tested with the data again - and so on, until we are satisfied that one of the emerging explanations sufficiently accounts for all the data we have assembled. This is known as negative case analysis (see Figure 3).

In summary, our analysis involves three stages.

- Sorting and organising data into whatever categories are suggested by the data (i.e. labels and concepts).
- Looking for meaningful patterns. Are there recurring themes or key issues? The aim is to recognise not just the frequency of these themes (should we discover them), but also their significance in relation to our research objectives.
- Subjecting each proposal to intense scrutiny.

d) **Drawing Generalisations from the Data**

Generalisation means making statements that hold true for a wider population than the sample. Generalisation refers to the norm rather than the exception: ‘In Australia, more women than men in the community report having health problems’ is a generalisation that is applicable in most cases - even though there are some women who may be enjoying better health than most men.

However, when we make generalisations we must have good reasons for claiming that what holds true for our sample also holds true for the wider population. We cannot ever prove that such a generalisation holds true unless we study the entire population; we can only ever assert the likelihood that it does.
Making generalisations in social research involves three main steps.

- We describe in a series of statements the pattern we recognise in the data.
- Depending on the nature and quality of our data, and the nature and quality of our sample, we decide if such statements are likely to apply to other situations. If so, we develop generalisations lifting our original statements from one particular setting to apply them to other, wider situations.
- From these generalisations we may then identify the logical implications. In community health research for example, policy recommendations arising from these implications may then be arrived at in consultation with various relevant agencies and community organisations.

Here is an example of the process of generalisation.

The Marion, Brighton and Glenelg Community Health Needs Assessment reveals that people in households with an annual income of less than $15,000 experience more emotional and social isolation, and energy problems, as measured by the Nottingham Health Profile, than those in higher income groups.

Though only a sample of such households were interviewed, we concluded that the result would most probably apply to all people in the area living in households with such income levels. (In Australia, people with $15,000 annual household income are normally considered to be living at the poverty line - at the present time).

The first level of generalisation might be that low-income earners living in Marion, Brighton and Glenelg generally suffer from emotional and social isolation and energy problems more than those with higher household incomes living in the same area. That is, there is an association between these variables that does not appear to be due to chance.

The second level of generalisation might be that since many of the social circumstances of low-income people in Marion, Brighton and Glenelg are likely to be typical of many urban Australian low-income earners, we can suggest that they too would be more likely to suffer from social and emotional isolation, and energy problems, than those with higher incomes.
In research reports, these implications normally form the basis of policy recommendations, presented (in the first instance) to the agency that sponsored the research. In the case of a needs assessment exercise, the data and explanations would be referred back to the project steering committee, and as far as possible, to the community for discussion about possible solutions to identified problems. Of course the substance of our generalisations would have been fed back to both, prior to the release of the report.

The Report

The challenge of reporting back is discussed fully in Section 5. However, as we contemplate our research report draft, it may be helpful to recall that the community that was the object of our 'needs assessment' is not 'out there' - we are part of it. Perhaps we should ask: Does our report reflect that reality? In what ways? Does our report gloss over the difficulties that have been encountered and only in small measure overcome? On the other hand, is the report perhaps too timid in expressing the most important of its conclusions?

For other considerations in relation to developing explanations, see 'Analysis and Report Writing' in Chapter 2 of this Section.

Computer Based Analysis of Qualitative Data

There are now computer software packages designed specifically to analyse textual information, such as field notes and interview transcripts. Two available in Australia are ETHNOGRAPH (Qualis Research Associates, PO Box 3129, Littleton COL 80161, USA) and NUDIST (L & T Richards, c/- Applied Computing Research Institute, LaTrobe University, Bundoora VIC 3083), which allow the user to search data not only for words that have been recorded or written down in interviews, but also for those ideas and comments we have recorded with the notes. This allows us to sort the information using our categories and labels, and then to test and challenge and re-build whatever tentative theories that may be suggested, by searching for data which calls such tentative conclusions into question. This is theory-building and theory-testing.
Ethnograph

Ethnograph runs on IBM-compatible computers using typed transcripts as data. A version for the Apple Macintosh should also be available in the near future.

The Ethnograph package is designed for use with the micro or ordinary desktop computer to accomplish many of the tedious and time-consuming tasks, such as preparing text for analysis and testing theories - processes which used to be done manually by photocopying, cutting and pasting, and sorting of coded segments of data into analytically useful and meaningful piles of indexed cards.

Like any analytical package, of course, it is not entirely straight-forward, and you should be aware that it may take some time to master it to do all that you want to be able to do; this should be taken into account in your research plan if you do choose to use this approach. It may be that your research task is not sufficiently large or complex to warrant it, and that this extra time may not amount to much less than if you had used the manual methods as outlined above. However, computerised textual coding systems which we can build with such software, allow considerable flexibility and creative exploration of themes and data, and the processes involved can be very quickly accomplished.

Other packages are now becoming available for micro-computers that handle considerably larger file sizes and levels of complexity than Ethnograph can handle in its present form. One such is NUDIST.

Nudist

NUDIST stands for 'Non-numeric Unstructured Data Indexing Searching and Theorising'. It was developed by Lyn Richards, a sociologist (to enable her to do justice to qualitative data generated over many years), and Tom Richards, a computer scientist and philosopher-logician, both at LaTrobe University in Melbourne. A version for Macintosh computers with a minimum of 2 megabytes of memory is now available, and shortly it will also be available for IBM/compatibles.

Nudist is a very powerful program and allows the researcher to ask questions of textual material, such as: ‘Give me all the material which has been indexed as about family life AND home ownership, elicited in interviews with young women who earlier in the interview talked of their isolation in some way'; and so on.
All the material that the computer retrieves from its data-base in reply is thoroughly documented, with all source details, including sub-headings, nearby. The material does not have to be on-line; units can be nominated for categorising and indexing data (which may be photographs, text, field notes, films, or whatever). This indexing can be at any level of complexity - from flat lists of codes to multi-dimensional tree-structures. Thus 'indexing concepts can be organised and managed as theoretical systems'.

Furthermore, the indexing system itself can be browsed or interrogated or totally overhauled as the research develops. Indexing categories revolve around viewpoints and encourage the exploration of meanings - not just labelling of data. This projects analysis into the arena of 'ongoing exploration of emerging ideas'.

Returning to our above example of women and isolation, additional questions could then be posed: does it matter if children are present? Is it different for older women? What does home-ownership mean to these women? New 'answers' become new indexing categories. Theorising can be recorded in memos stored online and indexed like any other document: along with comments. 'The system thus supports both theory-testing and theory-construction, and encourages both' (Richards & Richards 1990a).

Computer-based methods, like all other ways of viewing and analysing data (e.g. by statistical methods), can steer a project down certain paths and so possess theoretical implications. All software should be used with the same self-consciousness as other methods. A simple analysis of main themes, however, may not be difficult if the user possesses at least a comfortable familiarity with computers generally, and some expertise with word-processing software. The Ethnograph manual is highly regarded for its clarity and practical examples. (More information on Ethnograph is available from SCHRU.)

Reliability and Validity in Qualitative Research

It is important that the data and the conclusions that form part of a needs assessment exercise are reliable and valid. This section will provide a brief introduction to this topic. Reliability and validity are relevant to all types of research. Qualitative research tends to be questioned more frequently with regard to these criteria.
In qualitative research, issues of validity and reliability are tangled. Here we will attempt to give some clear guidelines, and point to some of the complexities of the issues raised by these concepts.

What is Reliability?

Technically, 'reliability' has been defined as consistency in the scores of a single measure (Bailey 1978:62). So, for example, a reliable thermometer must repeatedly give the same reading for a given temperature. In laboratory-based research, reliability is proven through repeating experiments to show they are consistent. For obvious reasons this is more difficult to do when studying individuals and communities in the world outside a laboratory.

If a needs assessment project was repeated in the same community even just six months later, it could be expected that the results would be different. Communities are dynamic and one of their chief features is change. A needs assessment conducted in early 1990 among the families of naval personnel may not have found stress and concern about the possibility of their relatives' involvement in war; by late 1990 this might well be an expected outcome. Similarly, the rates of overseas immigration into certain communities in Australia suggest that the results of a needs assessment done at one point in time would be different from those obtained later. Consequently, regardless of the methods and designs employed, no study can be replicated exactly (Le Compte & Goetz 1982:35). Nevertheless, to make a project more reliable and repeatable, we need to document the research process, physically, socially, and intellectually, so that if our project is to be repeated, at least in some respects, other researchers will be able to find out what we did and who with, and so on.

What is Validity?

There are three forms of validity.

Face validity - this is concerned with an assessment of whether the method of study (interview, participant observation, focus group, for example) is assessing what it set out to do. For instance, a focus group comprised solely of men would lack face validity if the group was for the purpose of studying women's health.

A study would also lack face validity if, for instance, a needs assessment exercise started off with the assumption that there were unlimited funds available to take action on the basis of the needs identified. This assumption would affect the questions asked and the approach to the needs assessment and make it quite invalid.
**Internal validity** - this is concerned with whether appropriately rigorous methods have been used in the study.

**External validity** - the extent to which the results of the research can be generalised beyond the sample selected for the study.

Needs assessment usually involves a juggling of internal and external validity. Sometimes the rigorousness of a method has to be modified so that generalisations can be made from the results.

A method can be reliable and not have validity. A set of scales might, for instance, tell you each time you use them that you weigh 55 kilograms; in fact, you may weigh 58 kilograms. Thus the scales are providing a **reliable** (consistent) measure, but in fact they are giving you the wrong weight and are, therefore, **invalid**.

**Ensuring Valid and Reliable Qualitative Information**

Ways of ensuring the information collected is valid and reliable are discussed throughout this Manual. These include:

- pilot your questionnaire;
- ensure your questionnaire is appropriate to the population you are working with; and
- ensure that your research method is sufficiently flexible to accommodate emerging concepts and ideas.

As emphasised earlier, an important way in which we can increase the validity, and possibly the reliability, of our qualitative research is through the technique termed ‘negative case analysis’ described earlier in this Manual. In this cyclic and stringent process, the researcher looks for data which might contradict hypotheses as they emerge during analysis; this leads to continual adjustments to the hypotheses until all the data is consistently explained. It can also serve to indicate areas where the data is unclear or inadequate, hence leading the researcher to question and improve upon the reliability of the data pool.

The use of a variety of research methods casts a wider net (Kirk & Miller 1986:26); recall the Smorgasbord of Methods described in Section 1. The use of several methods does not guarantee validity (Fielding & Fielding 1986:24-26) but it does provide a cross-check of results, thus increasing validity. However, we should not worry if data from one method seems to contradict other data. We are unlikely ever to find ‘unquestionable truth’. But reasons for the contradictions should be sought and explored. The crucial thing is to ensure that they are **real** differences in experience or
understanding and not a reflection of the methods used to collect the data.

The very flexibility of qualitative data increases its validity. When we use a structured mail questionnaire, for example, we have little scope to clarify intended meanings or to allow the respondent to present a viewpoint that is markedly different to that implied by the questionnaire. On the other hand, in qualitative research, it is possible, for example, to shift the agenda mid-way through a focus group or an entire project and permit new ideas to come into the study. This flexibility is an essential aspect of good needs assessment.

Results from a needs assessment study can be compared with those of other needs assessment exercises and with literature relating to health. If there are differences, then these might be explained, for example, by reference to the particular character of the population in the study area, or to the inadequacy of former methodologies upon which the literature may be based (Richards 1990).

When data is analysed, we have to represent what has been observed, with categories and labels, which we have discussed. An important part of needs assessment involves deliberately placing before the steering committee and community members, our evolving ideas about these categories, and the tentative theories built around them. Thus the results of the research are subjected to critical consideration before we reach the stage of forming conclusions. In this way, internal (conceptual) validity is enhanced throughout the life of the project (Le Compt & Goetz 1986:35).

The final stage at which validity of the results can be increased is during feedback to the people who provided the information (see Chapter 1 Section 5). In this process, we try to find out whether the analysis reflects the viewpoint that the providers of the information wished to have presented. Is the interpretation of the data accurate? If the analysis is not accepted as valid by the people in the community, then the face validity of the needs assessment is likely to be questioned. The project, therefore, is likely to have failed to be a truly co-operative one, with significant involvement lacking by members of that community. But we also have to ensure that this final step to enhance validity is not a token one; and we must consider such questions as ‘How willing are community members to voice disagreements?’ and ‘How far out of our way are we prepared to go to hear them?’
Figure 3. Main Differences in Analytic Approaches between Quantitative and Qualitative research

Quantitative methods (Deductive Approach)

- Theoretical framework
- Specific hypotheses
- Experimental or quasi-experimental methods
- Statistical tests
- Hypotheses rejected
- Hypotheses upheld
- Theory testing

Conclusions... never 'the whole truth'... always open to argument.

Qualitative methods (Inductive Approach)

- Theoretical framework
- Observation
- Analysis
- Tentative ideas
- Searching for cases that refute our tentative theories
- Observation
- Analysis
- Refinement
- (Involves some theory testing)
- Modified ideas
- Refinement
- (Involves some theory testing)
- Modified ideas
- Refinement
- (Involves some theory testing)
- Observation
- Analysis
- Refinement
- (Involves some theory testing)
CHAPTER 2 - Participant Observation

Introduction

Participant observation (PO) is a combination of observation, participation and discussion; each moment is a source of information. To extract and utilise the significance of social interactions requires considerable sensitivity, imagination, and commitment to the community or organisation being studied. PO demands time, patience, energy, initiative, and commitment from the researcher. The degree of actual participation in the daily life of the community will vary markedly, depending upon the researcher, but we must not forget that by virtue of us being there, we participate to some degree. There is no such thing as purely objective observation in social research. The important thing is that we are very aware of what we are doing all the time (Wadsworth 1984:40).

However, whether we adopt an openly active role or a quieter one, we always need to inform people of what we are doing. It is not a secretive operation.

Participant observation is perhaps the most challenging and demanding of all qualitative research approaches, as it involves close social interaction with the community under study, in order to observe first hand what people do, what they say, and what they say they do. An astute and thoughtful community health worker should be in a good position to become a participant observer in their field of work.

An action research (or advocacy) model for incorporating PO may be appropriate. Our aim would then be to feed back our results, as they emerge, into the community-based decision-making body, which then would choose the next direction, and build its own theoretical framework as it continues, until it reaches its own defined goals.

Researchers can take a relatively structured or unstructured approach to PO. A relatively unstructured approach has no rigid theories and uses no structured research instruments. In a more structured approach, the use of such an instrument as a check-list of items that should be observed, may be appropriate. In the latter case, however, we would need to be aware that such a check-list may cause us to become side-tracked and some important events
may be missed. Lack of flexibility may prevent community members from being able to shape the research agenda. Therefore, if such an approach is chosen, the check-list itself should be worked out with the steering committee and community members. On the other hand, we will be looking for data that is pertinent to health-related issues, so our outlook will never be entirely unstructured.

With in-depth interviews and focus groups, our relationship with the people providing the information is generally confined to the actual interview or discussion. By comparison, PO typically requires a considerably greater interaction between the researcher and the community.

**Preparation: Entry into, and Acceptance by, the Community**

Entry into the community, which implies acceptance by the individuals and organisations, is a necessary preparatory step even in a metropolis; it must take place prior to discussion and close observation. The ease or difficulty experienced at this step may reveal important matters of power in the community which could be noted for later reference concerning who to interview, and why, and how to go about it. Significant resistance may come not only from key individuals or organisations, but possibly from an entire ethnic or racial group, depending on the topics being researched. This is certainly the case in relation to the investigation of Aboriginal people and of issues that concern their health. They have indicated that they feel they are the most researched people in the world.

The manner in which we gain our ‘credentials’ for community research is not decided by us, but by the relevant organisations that represent the people with whom we wish to work. Tact, diplomacy, honesty, and patience are all called for at this critical entry stage. We must go through the right channels, otherwise our credibility, and that of future researchers, may be harmed.

In the following discussion we will assume that the project has been shaped collectively and is aimed at helping the local people plan healthy communities.
Having gained acceptance by key organisations in the community, the researcher should be in a good position to commence observation and to pursue leads which open the way to local people outside these organisations.

Most community health workers have to rely on client contacts and professional networks in the course of their normal jobs. If researchers live in the area of study (at least for the duration of the research), or if they have other involvement besides work in that community, they are more likely to be in tune with the most important health concerns, and with other community dynamics.

Make Contact

There are a number of steps involved in making contact and establishing rapport with key organisations.

- Identify those agencies and community groups associated with health and community services; make contact with them and explaining the aims of the research; be clear about any assistance you may require.

- Community groups are generally willing to help with health research, because they believe it could lead to better services, or bring favourable publicity to them; however, you should be aware of unwritten political agendas, as particular community groups may attempt to hijack the research for their own ends.
Avoid relying on too few individuals or agencies for gaining acceptance in the community, as the research might be seen as motivated and sponsored by those particular persons or associations; make yourself, and the research, widely known and get as many people involved as possible.

Be open to all that is taking place in the community, as most social problems have implications for health when viewed from the social health perspective. For example, if the local bicycle club is concerned about heavy road traffic, go to their meetings and talk to them.

Identifying Issues and Information Providers

Preliminary explorations should explore all the obvious questions, such as:

- What are the main concerns of the community?
- What socio-cultural, environmental, and other factors appear to be associated with the health problems of the area?
- How do people regard their health and health care services?
- Are particular reasons being suggested for the various points-of-view?
- Are minority social groups especially critical of the level of care they experience?
- What are the most influential community groups and associations?
- What is the discernible power and leadership structure of the community or region?
- What is the role of local government?

Preliminary information-gathering, together with document analysis, will have suggested some answers to these questions. Sources of health-related information include case files or contact records which health workers are expected to keep, anonymous versions of which may be available to help at this initial stage.

With this information, we may be able to decide what other issues must be considered in order to address the likely health needs of different social and economic sections of the community. Such information contributes to the community profile, as outlined in Appendix 1.1.
Some Problems and Principles of Participant Observation

The relationship between the researcher and the people providing the information is complex and sometimes difficult. Unlike one-off interviews in a survey, participant observation demands both detailed personal responses from people and interactions extending over long periods of time. Difficulties may include personality clashes, where the researcher and providers of information simply cannot get on with one another; or loss of interest if discussions are carried on over too long a period; the investigator may be told outright lies, or be set up by someone to look very silly.

Overcoming these problems depends more on researcher's ability to get on with people than on research techniques. Such skills are very similar to those needed by a community development worker. The following tips may be useful.

- Appeal to the self-interests of the people providing information, by highlighting what you perceive to be the benefits of the research. However, you must be careful not to raise people's expectations to unrealistic levels. Of course, if they make it abundantly clear that your research is not welcome, then you should pack your bags and depart. **You should never assume that you will be welcome, and you should aim to learn, more than to inform.**

- Find ways to encourage the community - especially those most powerless - to take an active part in the research. Ideally, local people should be on the steering committee, and it may be appropriate and possible to employ some of them for various tasks.

- Publicity is important in smoothing the path for fieldwork. The local newspaper, notice boards in churches, supermarkets, public library and community centres are obvious venues. The right words at school teacher-parents' nights, for example, may go a long way towards creating local awareness of the research.

**Be Flexible**

It is useful to compile a list of organisations and individuals. Nevertheless, be flexible and recruit new people during fieldwork, or when events happen that force a change of focus.

For example, an environmental report may be released during your research which may suggest that polluting emissions from local
factories are contributing to health problems in the community. As a result, the community may lobby for certain industries to be relocated and your attention may be directed to issues unforeseen in your initial plans.

Getting Your Hands Dirty

Participant observers must spend as much time with the information-providers as possible. Gaining the trust and co-operation of the community is essential. To be able to notice the significance of social interactions requires sensitivity to wider social forces and their impact on the area, as well as to the variety of ways individuals express their situations. It also involves creativity.

For example, to accompany a single parent on a trip to the supermarket would be an invaluable opportunity for fieldwork. Helping with the trolley, and seeing how grocery items are chosen, would bring us face-to-face with information about weekly family budgets; food preferences - fresh versus frozen/convenience foods, branded versus under-advertised products; and dietary preferences within the family. A shopping trip would be a good setting to discuss not only the effects of inflation in relation to the problem of balancing the budget and of reconciling good diet with value-for-money purchases, but also perceptions of the area generally and how it has changed. Hence it may also alert us to the lack of choices available there.
There are several points to note.

- You should not be too concerned initially with what you can get out of the interaction, as the significance may only be realised later.

- You should casually ask questions while actually involved in social activities, as this allows people more time to reflect on what they are doing and why. Their answers will spring from the different opportunities presented to them in this setting, compared with those of a formal interview.

- PO is an open research experience. You cannot be inflexible about whether to interview or observe or participate, or when to begin and end. The shopping trip is a good example of how the information gathering has to flow with the event, rather than being controlled by the researcher.

- You must respect the wishes of people and not disrupt their work and routine. In fact, you may obtain more important information when you allow people to carry on their activities without focussing upon their involvement in the research project. They will no doubt be aware of it anyway, but there are ways of ‘playing it down’, of letting them lead.

- Sometimes you may wish to use a formal interview, for example, with people with whom it is not possible to spend much time. You can ask people to explain and elaborate on some things you have observed - and to reflect upon your evolving theories and explanations. Researchers need to be alert to cues which provide this opportunity for discussing important topics.

For needs assessment research, there are many opportunities for useful observation. Spending time with a client family at a community health centre could be important. Be imaginative about the type of situation observed. For example, instead of interviewing older people about their health needs, you could spend a day with a widow pensioner or two, take a bus with them to the bank and shopping centre, or hospital, or local health service.

**Cultural Considerations**

It is highly likely that at some stage you will find yourself observing and interpreting the activities of people who are not of your ethnic or cultural background. The following example illustrates the importance of cultural considerations in the interpretation of street violence.
Suppose you begin with an interest in aggressive behaviour among adolescents of different cultures. Don't you simply go into various cultures and observe adolescent aggression? Of course, but what kinds of behaviours are valid indices of aggression? Aggression, after all, is only a theoretical concept, not a behaviour. It is the name we give to a class of behaviours, and even in our own society we are not sure which kinds of responses should be counted as part of that class (Segall, in Reser 1990).

Hitting someone on the back is a good example of an action that, depending upon the socio-cultural context, can mean quite different things. So, we must beware of drawing hasty conclusions. If in doubt, seek out advice, and not just from 'experts' but from shop-keepers or people waiting at bus stops.

Keeping Notes

There are three types of records that researchers may keep:

Diary

Note in a diary what is done and with whom you spend time. Such notes should be brief records of activities, and strong impressions of observations and interactions with people. The diary acts as a reminder and may be separate from other field notes. It also provides the most accurate account of the progress of your work over time.

A typical entry may be:

'21 Nov Tues, spent A.M - Mrs Smith in her home, later accomp. her to clinic for wkly visit. Much info on the state of clinical services for pensioners and her perceptns; should pursue. P.M: typed field notes; and tried contact Dr Jones, reg'str at the Commy Cent, spouse said: 'away until Dec 12th'.

Brief Field Notes

Make brief notes of observations and interviews - on easy-to-carry index cards or in small notebooks; these notes will be expanded later, preferably on the same day.

Note-taking during fieldwork should be as unintrusive as possible. Sometimes the process inhibits conversation, or is considered ill-mannered (for example, taking field notes when the family members are gathering at the bed of a patient who has just emerged from an operation). Key points should be remembered
and jotted down at the first opportunity (in the outside waiting room or in the car).

Put in quotation marks the exact words or phrases found striking; for example:

'I had to wait six hours before a doctor came to see me.'

These exact quotes must be distinguished from your own comments; for example:

Accomp client to two depts, X-ray and physioth. Two appts in one morning. Client very tired but preferred to make only one trip for transp problem.

Rose (1982:114) recommends this useful and simple method of notation, adopted by anthropologists Schatzman and Strauss (1973:Ch.6):

<table>
<thead>
<tr>
<th>Notes should be organised according to this neat scheme:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ON</strong> (observational notes) - on what happened, with little or no interpretation. ‘An ON is the Who, What, When, Where and How of human activity’ (1973:100).</td>
</tr>
<tr>
<td><strong>TN</strong> (theoretical notes) - self-conscious, controlled attempts to derive meanings from any one or several ONs. The observer ‘interprets, infers, hypothesizes, conjectures ... develops new concepts, links these to older ones, or relates any observation to any other’ (1973:101).</td>
</tr>
<tr>
<td><strong>MN</strong> (methodological notes) - mainly reminders and instructions to oneself, for example on the validity of the ONs, critique of what one has done, and notes on what to do next.</td>
</tr>
<tr>
<td><strong>ONs could also include PONs (personal observational notes)</strong> - references which describe how the researcher is feeling and other personal impressions - which may later be incorporated into the study reports. A further category could be <strong>FON</strong> (forgotten observational notes) - previously-forgotten happenings that are now recalled.</td>
</tr>
</tbody>
</table>

This scheme helps us to monitor difficult, less structured projects, to determine, for example, ‘Where have we got so far?’ and ‘What do we do next?’. Also, says Rose, the presence of the TNs makes it clear that data analysis should be an on-going process. The natural history of the project (which is described in the MNs in particular, plus additional notes), is an important part of the research and
hence should also be outlined in the final report. The PONs provide an honest description of the actual research process, which aids project reliability - too often neglected or frowned upon by those in the physical sciences community.

Detailed Field Notes

It is important to expand the brief field notes and diary notes at the end of the day whilst your memory is fresh. At least a couple of hours each day needs to be set aside to reflect and expand on what has been learned. This must be structured into your schedule. It is not an option; it is an essential discipline.

Expanded field notes should give, besides a record of the fieldwork, a 'feel' of the encounter - where it occurred, the weather, the mood between you and the people providing information. These details provide not only 'colour', but understanding of the social context from which your data derives its meaning.

Detailed field notes using the 'TN', 'ON', and 'MN' notation method, may look something like this:

Date: Wed. 22 November 1989
Informant: Mrs. Jane Smith

(ON): A bright summer morning. Feeling OK despite serious hay fever. Drove to Jane's place in Christie Downs to accompany her to Flinders Medical Centre for monthly check up.

She lives alone since her husband, a fitter and turner with the Mitsubishi car firm, died in 1980. She has three sons all living in Sydney, and a daughter married in Adelaide who comes to see her once a week to help her with shopping.

Jane has had hypertension for the last 6 years. She is given medication, and has a monthly check up at FMC. She says 'Six months ago, I had a heart attack and the neighbour phoned an ambulance for me. I feel old and helpless. I can't exert myself, and you can see, the garden just got neglected. The doctors say I must try to keep a low fat diet, and some light exercise. But you know I like my meat and potatoes; nowadays I don't have much appetite so the diet issue doesn't matter anyway ...'

Drove Jane to FMC - arrived at 10.30 am for the 10.45 am appoint. Waited outside the consult room. Weather much warmer. She looked exhausted with the heat. Went for a drink at cafeteria - she ordered orange juice.

'Dr Jones is a nice doctor; very kind to his patients, always explaining what he can do for you. ... He told me that I should continue with the medication for the next few months, and perhaps go for a holiday. I am going to see Tom (the second son) in Sydney over Christmas. ... I get dependent on Christine (the daughter) too much.' I asked her if she enjoys coming to the hospital. She replied 'There is not much to enjoy. But I suppose it is a trip away from the house. This is nice hospital, the doctors and nurses are very good to me.' Took Jane home at 2 pm.
"(TN): Jane is typical of many older people in the community. She experiences social isolation since her husband died; all the sons having moved away and the only daughter is too busy with her own family to give the mother more help. Transport is a problem. A round trip by bus from her home to Flinders Medical Centre takes 3 hours including waiting time.

On the whole her perception of the Medical Centre is positive. She even enjoys the monthly trip as a way of getting out of the house - though more frequently than that would be a burden.

(MN): To follow up: Contact her physician and ask for an interview, and perhaps observation of consultation if all approve. Find way to make this arrangement. Must further discuss Jane's perception of dietary recommendations, and problems of keeping healthy diet. Phone her and go shopping next Thursday night.

From the example, three things should be clear.

- There are several components to the field notes - background data of the people providing information (you may also like to note these as BG); PO data reporting your interaction with these people (ON); direct quotes from these people (part of the ON but deliberately put in quote marks); your analytical impressions (TN); things arising from fieldwork that need to be followed up (MN).

- Expanded field notes are detailed records written in more leisurely and reflective style at the end of the day. The purpose of field notes is not only to record what happened, but also to think about the significance of interviews and observations made.

- The 'ON-TN-MN' method helps clarify field notes. It also helps you become a more astute and theoretically aware researcher, as you learn to distinguish observation from impressions, and from interpretations of events. In addition, it assists when you try to make sense of the notes you have accumulated. This is so, whether you are using computerised analysis or not - but especially if you are using a program such as Ethnograph (described in the previous chapter).

Sometimes field notes will not focus on people but will attempt to capture the 'feel' of a community, which may later be used to introduce the substance of your research; for example:
Date: Tues. 8th September 1989 4.00 pm.

ON: weather: sunny I cycle through the street (TN named by many people as the worst street in Christles Downs). It’s a warm sunny late afternoon. The housing is single storey, joined housing. There are open front gardens. Lawns are mostly well kept and flower beds are generally neat. An older woman is tending her plants. She is carefully trailing some climbers up her front wall. Further down, two young men stand talking in a front garden. Four or five stand around talking by another front door. All hold stubbies. All look at me as I go past. I am afraid to hold their gaze for too long. Down on the corner, in another garden, a small child rides happily up and down the drive on a toy train that makes the sound of a whistle as she moves. Two adults are talking in the garden, perhaps her parents, the man dressed in motorcycle leathers and a sleeveless denim jacket. As I turn the corner I see his black motorbike standing outside the garage. Their child plays on. A bright orange panel van, with wide wheels slides around the corner and parks. Another two young men wearing black t-shirts and faded jeans climb out and walk over to a neighbouring house. They too are carrying stubbies. There is a lot going on.

Participant Observation and Time

In the above example, Mrs Smith suggests that the main feeling of loneliness comes from the fact her grown-up children have moved away and her married daughter, living in Adelaide, rarely comes to visit because of the demands of her own family. An issue has emerged: ‘the lack of family support as the main cause of social isolation’. To explore isolation further, it should be pursued with the next person. He or she may present an entirely different picture. One does not negate the other - each would be valid.

Fieldwork may give us a sense of a plot - in this case about health and community needs - evolving with each observation and interview. Though PO is time consuming, a health worker could, to a large extent, integrate fieldwork into his/her daily routine. This may require some re-scheduling of time and work duties. Management support will obviously be necessary; negotiate for sufficient time to engage in such research.

How Much Time Should Be Spent on Fieldwork?

How long should be spent with Mrs. Smith? PO demands considerable commitment from both the researcher and the community. A typical fieldwork period could involve six months. Experienced community workers, if locally based for a long period of time, may have achieved considerable ground work through observation and interviews over many years. It may be useful to set
up a small research reference group in your health centre, to gain support from colleagues and to incorporate their experiences.

**How Do You Know When You Have Sufficient Information?**

There is no straight-forward answer. You may know you have done sufficient field work when certain themes continue to emerge. If you have worked consistently, spent considerable time with people, and all leads have been followed, your impressions may lead you to conclude that all important issues have been explored. You may already have a clear idea of what your final report will look like. This would be the signal for winding down; there could also be budget and work constraints. You may succeed in generating enthusiasm in the community for social health issues, in which case it would be a simple case of ‘handing over’ completely to let them run with it.

**Analysis and Report Writing**

During field work, you should be continually reflecting on what you are discovering - and subjecting your emerging categories, ideas, and labels to critical appraisal by members of the community and steering committee. By the end of field work, you should have a clear idea of the main themes you wish to report, all of which will have appeared in some form in your field notes.

The expanded field notes are your source of inspiration, on which you have built your interpretations of what you have seen and heard. Read them again carefully. Summarise each paragraph by writing down the main theme or themes next to them. **Recall that we gauge the significance of the issues that arise by looking at their relevance to personal and social health.**

Information gathered from participant observation is a combination of verbal statements and observational data. The two types of data enrich, but do not always confirm, each other, and these subtleties should be fully exploited in the analysis.

When verbal reports are supported by your observations, this should be made clear. For example, ‘lack of kin support’ may have been noted as you listened to your subject talk about her family. This is clearly a source of loneliness, and if it deeply concerned your subject, you should have noted how you came to assume this - tone of voice, words used, body posture, and so on.
In the Noarlunga study, people on the whole expressed great concern that their (grown up) children did not visit them enough, or had moved away to other cities apparently ‘without much thought for me’. This was also evident in our observations:

Of the 10 key people we regularly interviewed, all except one have married children living in other cities. One person, a women of 65, has a daughter in Adelaide who, because of her own family commitments, only visits her mother once a fortnight.

When observations appear to contradict what a person has said, you should try to understand the reasons for such apparent contradictions. This may become an important aspect of your analysis. It is not so much the contradiction that matters, as the fact that different social circumstances can yield different perspectives on the same matter. Each are valid in their own right. Each convey important social meanings.

Always include sufficient cases to back up your conclusions, together with the reasons for choosing them. These examples should be made clear in the final report so that the reader is able to decide whether an alternative explanation might apply to those cases provided. Without doing this, your conclusions may only be regarded as anecdotal in character, i.e. your case-studies could be viewed merely as those chosen to support your line of thought.

If you have gathered some case-studies which appear to challenge your conclusions, but which you can account for, then you should provide examples of those as well, together with your reasoning.

Write conclusions in simple, clear and unambiguous language. Try to hone them down to short and easily-understood statements.
CHAPTER 3 - In-depth Interviews

Interviews: A Shoe in the Door

The interview may be the only method for exploring our main topic. As with other methods, information obtained this way must be considered in relation to its setting. What is revealed may be different to information that is revealed through other means; and there are many types of interviews, all of which gain their structure and style from their setting and the topic being investigated.

Just as surveys are widely believed to be objective and reliable, the interview is often assumed to be a straight-forward process of 'fact-snatching'. Market research interviews, so common nowadays, are often quantitative research projects aimed at establishing who is eating or watching what at a given time: 'Yes, I eat chocolate', and 'twice a week', and so on. This model of interviewing - using highly structured questionnaires with one shoe in the door, a highly rehearsed emotional (i.e. happy and disinterested) approach, and its string of boxes to tick - has led to a devaluation of the role of interviews, and it has contributed to the idea that data derived from such projects have no wider social or political implications. However, the interview, especially when used in conjunction with other approaches, remains a powerful tool for social research.
Interaction of Interviewer and Interviewee(s)

An interview is an unnatural social situation, an expression of a certain kind of relationship between researcher and interviewee. Even a ‘cool’ and detached approach may tell us much about the type of knowledge the interviewer possesses of the interviewee, and how interested that interviewer is in the actual substance of the interview. A typical (mental) response from a householder on the doorstep may be . . . ‘Well if they have no personal interest in the information I am supposed to divulge, why on earth should I tell them the truth?’ This leads us to be wary of survey research of this kind, especially when it moves to more personal issues, such as ‘income in the household’. On the other hand, the anonymity of telephone interviews allows some people the freedom to provide more personal data than they would in the context of a face-to-face interview.

It would be mistaken to assume that if an interviewer adopts a cool, detached frame of mind and body posture, he or she will not influence the outcome of the investigation. People do notice the researcher (can you remember the last time you were interviewed?), and they do react to the research process, even if they do not ‘let on’ about it.

| Q. When is an interview not an interview? | A. Perhaps when it is a discussion. |

Qualitative research creates a variety of interviewing situations. Researchers are not passive recorders confined to asking straight-forward questions and taking down simple answers. Interviews may develop into lively discussions. On the other hand, some people need to be encouraged and prompted to give answers which are as complete as possible. Interviewers may have to take on a provocative role in order to elicit more elaborate responses. A most useful question is ‘Why do you say that?’.

Qualitative research demands a certain amount of special preparation and knowledge, besides personal, relational skills. We need to be alert - ready to follow up interesting and possibly significant viewpoints. Interviewers also need plenty of energy; as Wadsworth (1984:32) has noted, interviewing is: ‘exhausting - our attention is needed throughout. We’re hard at work communicating the whole time - so we should not try more than 3 half-interviews in a row. If they are an hour each, 2 or 3 per day will be plenty’.
Gaining an 'Inside View' to Enhance Interviews

In qualitative research, you may wish to involve yourself as far as practicable in the world of the people providing the information, to gain some first hand knowledge of their cultural and social context, and even to be directly involved in the activities of that community. This is not easy, but information gained as an observer or participant will assist you to assess and interpret what people are saying in interviews.

In-depth Interviews

In-depth interviews involve a series of face-to-face, detailed discussions with selected people who we believe represent different sections of the wider community. This idea of 'representativeness' will guide decisions about who to interview. In-depth interviews are more informal and less committed to an agenda than interviews conducted in surveys; however, a semi-structured question guide, framed around 'key discussion points', is a useful tool. As Labaw (1985:12,13) has stated, 'a questionnaire [of this type] is much more than a set of questions. It is a totality . . . with each part vital to every other part'. This approach to interviewing, she proposes, can have a 'considerable impact on the search for meaningful results' (ibid.). Using this form of discussion guide can often be a useful compromise where a questionnaire is considered unsuitable, as it ensures the main topics are covered, whilst allowing the flexibility required by qualitative research.

Who to Interview?

Before you invite people for interviewing, you must be clear about who you want. The question of who and how many will depend on three things:

- the recruiting criteria;
- the budget;
- the subject of research.

All interviewees should be able and willing to contribute substantially to a relatively lengthy and open discussion but, at the same time, you must ensure appropriate representation of the community.

Are you trying to find out about older people, younger people or the whole community? What do you know of a particular group's
social and economic characteristics? If you are planning research on the health needs of older people in a particular community, your recruiting guide may need to consider several factors.

- **Age and sex:** 65 and above, men and women.
- **Income group:** to have a representative coverage, you need to invite people from all income groups.
- **Language/cultural background:** if you are dealing with a community which contains non-English speaking people, they should be invited and interviewed if possible in their own language(s). This can be achieved in a variety of ways: by a paid interpreter; by a health worker with language skills; by a family member with good English skills (not suitable for some topics which may not be open for discussion within families). It may also be necessary to learn important cultural modes of expression, gestures and the like.
- **Special criteria - what is the primary research issue?** Some communities may have specific health problems. Pollution caused by factories in the area, for example, may be thought to be contributing to a high incidence of respiratory illness among the aged. To enable people to talk about this in relation to their health needs, a recruiting guide may be: ‘has suffered from a respiratory illness during the last 12 months’.
- **Household structure:** are people living on their own?; with a spouse?; with other adults they are not related to?

**How Many? How Much $$**

For in-depth interviews, you should aim to interview a minimum of 20 people; but bear in mind the following:

- **Do you want to generalise to the whole community or not?** Generalisation to a particular group may be sufficient.
- **How is the data to be analysed?** Be aware of the need for considerable time at both preparation and analysis stages, regardless of the means of analysis utilised (manual or computer-based). Remember also that the number of people you interview will affect the costs.
- **Time per interview:** expect to allocate at least three hours per interview, including travel, and approximately three times the actual interview length for transcription (if the interviews are to be transcribed in full - this however may not be possible or necessary). Are there interviews for which we need to employ others - for example, those with
non-English speaking respondents? If so, additional expense will be incurred, both for conducting interviews and for translating tapes.

- **Representation** - in relation to budget. Looking again at the timing and budget may force you to trim the number of respondents. The general principle is to leave out those you think will make the least difference in terms of representing the target group. Use common sense and your knowledge of the community.

The Discussion Guide

To carry out an in-depth interview, a discussion guide may be used. This can be a simple list, roughly in the order you would like to deal with the topics. A well-constructed list of topics will ensure that all the essential issues are covered. Here is an example of a discussion guide for the health needs of older people:

**In-depth Interview Discussion Guide: Needs Assessment of Older People in Noarlunga Local Government Area, South Australia.**

- Introduce yourself and explain the purpose of the interview.
- Warm up: obtain a brief personal history - age, family and education.
- Discussion of Issues.
  Profile of work outside the home before retirement:
- number of years;
- nature of work;
- working conditions;
- occupational hazards;
- industrial injuries;
- history of industrial-related illness.

Leisure-time activities:
- hobbies and exercise: what and regularity;
- perception of available facilities, especially difficulties in using them;
- community centre: availability, how useful;
- overall evaluation of community facilities and help.

Present health:
- overall health, general sense of well-being;
- any chronic complaints;
- experience with doctor, physiotherapist, and community health workers;
- evaluation of curative experiences;
- perception of available health services, adequacy, quality of encounter with health professionals.

- Suggested improvements: what can be done.

- Finishing up:
  - general discussion about social and health problems of older people to check that topics of importance have not been missed.
  - future prospects and aspirations.

- Thank interviewee - inform that he or she will be sent a short summary of results, and encourage any further questions.

This is a guide only, but it should cover most of the issues to allow respondents to explore their health needs and social situations. Notice that:

- You gradually build rapport with the interviewee(s) by asking them to talk about themselves and their families. This helps to create a casual atmosphere. The brief personal history gives a background to what the respondent is going to tell us.

- The topics should follow logically from each other. For example, it is better to have a brief employment history before you come to asking about present health status.

- In the topic guide, be clear about the issues most relevant to health; such issues might include: occupational experience
before retirement; exercise; the quality of social amenities; encounter with health professionals; quality of health services; local environment; duration of residence in the area; social interaction, including family.

In-depth Interview Settings

Choose a setting that is comfortable. Sometimes it may be more appropriate in the person’s home, but we may face interruptions from children or television, for example. If conducting an interview away from the person’s home, a cup of tea or coffee at a cafe may be the right place if it is quiet enough - wherever it is most relaxing. In-depth interviews are best tape-recorded, but if any resistance to this idea is encountered, use a note-pad prolifically.

Confidentiality

Permission must be sought from each respondent before tape-recording interviews with them. A signed guarantee should be given to the interviewees which ensures that all information will remain confidential.

For tape-recording, a fairly quiet setting with few distractions is required. A simple but too easily forgotten reminder: check your equipment before each interview. Make sure that the tape recorder - especially the microphone - is working properly, and have spare fresh batteries and tapes at hand, (and check that there is a tape in the recorder!). This will avoid a lot of frustration, and even embarrassment. Use 90-minute tapes, as 120-minute tapes stretch too easily. A tape recorder with a tape counter will also help you to note, and locate later, the appropriate tape segments.

Who Does the Interviewing?

It is important that the researcher (or a member of the research team) conducts all the interviews. Qualitative interviews cannot be delegated to people who are removed from the project. Language barriers are the only reasons for being unable to conduct interviews, in which case you would ask an interpreter to conduct the interview for you. It is a good idea, however, for you to be present at such interviews, to maintain a monitoring and recording role.
Listening Skills

In-depth interviews involve a two-way exchange or discussion. You need to get away from the type of interview situation where one person asks questions and the other answers. You must listen intently and encourage the interviewee to suggest items of personal concern and interest. Let them set the pace and, when introducing topics you consider to be vital, always be ready to back off if any reluctance to explore them is evident. Such reluctance may be a signal that your preparatory work has been inadequate.

You should not dominate the topics of discussion; above all, you should never impose your own viewpoints. Wadsworth (1984:30-32) provides practical advice about listening.

You try and be a Good Listener. You concentrate, are tolerant, empathetic, encouraging, agreeable (in the sense of not projecting a stony face), you go “mm” and “uh ha” to show you are listening . . . You try and Hear. You actually “take in” what you’re listening to. You don’t skip ahead thinking “I know what she or he means” - you wait, and ponder it - are you sure you understand what they meant when they used such and such a word? You actually “hear” the unexpected answer - it pulls you up and you think “Oh I had that wrong”; and you “hear” if the answer is unsure, confused, not really relevant, or seems to be just saying what is expected, commonplace or otherwise “imposed” . . . and you check it out.

The flexibility to probe and check intended meanings is vital . . . ‘do you mean . . . are you sure that . . . I’m not sure I got what you were saying about . . .’

When Things Go Wrong

If you find that you cannot develop an acceptable level of rapport with the person being interviewed over an hour or so, be prepared to politely withdraw from the interview and find another interviewee. But this should not be done lightly, and in any case the substance of what that person was saying remains a part of your data and may be worthwhile following up later.
Analysis Guidelines

The purpose of analysis is to examine and interpret critically all of the information we have collected, to clarify any outstanding issues, and to establish themes - or perhaps even the absence of themes.

With respect to interview data, we must recognise that:

*More than one interview with the same person will inevitably result in variation in what was said and how the respondent presents him or herself. If we recognise that such variations are important data in their own right, it becomes theoretically possible to exploit this by repeated interviews, thus giving an opportunity to analyse systematically the apparent contradictions and the ambivalence noted when only data from a single interview is available* (Pill 1988:145).

As we listen to the tapes the first time, we should be sensitive not only to general emerging themes but also to areas of ambivalence, and perhaps confusion. It may even be advisable to re-interview at least some people to explore further these uncertainties.

Transcription of tapes is a costly and time-consuming exercise, and should be kept to a minimum. However, if the intention is to use computer software such as Ethnograph for the analysis, transcription may be essential. If you have done the interviews yourself, listening to the tapes should be sufficient for getting all the important points on paper, using the ‘ON-TN-MN’ notations described earlier in this Section. You should not have forgotten to note the most important non-verbal cues such as emotional expression (including the intensity or the lack of intensity of feelings), extensive pauses, resistance to certain topics, gestures, inflections in voice tone, and so on.

To provide background information for recorded interviews, you also should have written brief notes on how you perceived your impact on the discussion. Other notes would have been added subsequently, for example, any analytical thoughts, or ideas for further fieldwork.

The major task is then to apply the analytic schema of building categories and labels to describe your data, and subjecting your tentative theories to critical consideration, as detailed in Chapter 1 of this Section. In particular, you must set your interview data alongside other interview data, and then alongside notes derived from observations. Conclusions will be drawn from interpretations of the data from all these sources, although information from in-depth interviews may be the most detailed, and hence may need
special care. However, when weighing up apparently conflicting information derived from different sources, we should remember that interview data represents only another perspective (not a better or a richer one necessarily).

Conclusion

An example of qualitative research is provided in Chapter 5 which illustrates that, as in most qualitative research approaches, in-depth interviews should be, whenever possible, supplemented by information derived from observations in the community.

In-depth interviews bring together the researcher and the person providing information to discuss important issues in a relaxed and leisurely environment. Since we are dealing with a face-to-face situation, usually without much structure, the researcher must be always handing back the reins to the interviewee or, at most, steering very gently.

In-depth interviews can provide valuable insights into community needs. By the time you carry them out you should have spent some time in the community, and got to know some of its most diverse aspects. This ‘inside view’ will give both the researcher and the research more credibility in the eyes of interviewees.

There are disadvantages to in-depth interviews.

- They are time-consuming. You should expect to spend from 2 to 4 hours on each interview to enable you to cover all the issues outlined in your topic guide. If you are interviewing 20 people, that would take a total of about 60 hours.
- It may be difficult to find respondents who have a good knowledge of the community and who are prepared to be interviewed.
- They can provide a mass of information very quickly which is not easy to sort and analyse unless you use such tools as the semi-structured interview schedule, the MN-ON-TN notation, or you carefully focus discussion around a few key topics.
- Without considerable skill on the part of the researcher in building rapport with a very diverse group of people, they may result in data from a relatively select sample of confident, articulate people - who may be the ones least needful of community services.
However, in-depth interviews, especially when combined with fieldwork observation, yield valuable information, and rewards can be high and well worth the effort and time spent. In particular, less structured interviews may yield opportunities for exploring underlying thinking patterns, and ways of talking about health-related issues which may be of particular concern to those directly involved in health promotion.
CHAPTER 4 - Group Techniques

Three group techniques will be discussed in this chapter - the focus group, the nominal group technique and the Delphi technique.

Focus Groups

Nothing Hocus-pocus about Focus

This is a technique which brings together up to ten people to talk about an issue. Focus groups allow respondents to discuss things among themselves, with the researcher monitoring and guiding the discussion. Increasingly, it is being used to explore health-related belief and behaviour in such diverse groups as husband-wife dyads (couples), extended families, individuals and their important friends, and community groups representing the views of people in certain social circumstances, such as residents of caravan parks, or members of certain racial/ethnic groups (Pill1988:146).

You should let your imagination consider how this technique could be utilised in a variety of social settings, and experiment amongst your friends and colleagues to help build your confidence for wider applications.
Group discussion is the key to the method, and a successful focus group is about creating a situation where respondents are encouraged to talk about things in the open.

Recruiting People

a) **How Many Focus Groups?**

The first decision you have to make is how many focus groups you will need to discuss community health needs.

As a general principle, the number of focus groups you organise will depend on the number of different sections of the community that have distinct health needs, for example, of different age or gender categories, racial or ethnic origins, socio-economic status, or geographic locations. Even within a gender category, it may be important to have one group for, say, single parent women and one for partnered women. Within an age category: one for teenagers who present ‘deviant’ images, and one for those who do not. All may possess different views regarding health needs.

Thus we recognise that a community is made up of people with different - and often competing - interests and with unequal access to resources. We should not forget that when we use the term ‘community’ or ‘community needs’, we are referring to groups of people with significantly different problems and needs.

After your preliminary research, you should have a fairly clear idea of these differences within the community you are studying. For community health needs assessment, the following focus groups would most probably be required:

- older people (age 65 and above);
- young people (from 16 to 20 years of age);
- families with children living below the poverty line;
- people from a migrant and non-English-speaking background;
- carers of older and disabled people;
- people with specific health needs;
- people with physical (or even, intellectual) disabilities;
- people from particular self-help groups;
- groups of men and women to discuss gender-specific issues.
b) **Participants**

Remember that you must select people who are not only knowledgeable but are fairly open. They must be able to express their feelings to the researcher and also in front of a small group of people, and be prepared to respond to what other participants say.

To achieve a good combination of people in a focus group, you may find it useful to bring together people who represent different sections of the community.

From your working experience for example, you may realise that there is a strong feeling in a particular community against the young, who are perceived as irresponsible, lazy and disrespectful of parents. It might be useful to have an optional focus group (for example, one made up of people who volunteer specifically to join it) consisting of young and older people who could be encouraged to express possibly differing views to each other, and to defend those views.

You can invite the participants yourself, or you can pass the word around and ask people in the community to look for suitable participants for you. It is important for you to be explicit about your recruitment criteria and the nature of the focus group.

Also, remember that there is no magic formula for a successful focus group. You will try your best to recruit the right participants,
but it is difficult to predict how they will interact in a group discussion and you should be prepared to repeat the exercise with a new group of participants if the original members do not seem to interact well or if insufficient information emerges.

Group Discussion Process: Using a Topic Guide

Since there will be a number of groups of quite different participants, a discussion guide will be needed for each group. Look again at the example given in the section on in-depth interviews. Make sure that the topics cover all the important issues relevant to the subject.

The Researcher as Moderator

The principle of a focus group is to provide a situation in which meaningful and sustainable discussion can take place. The discussion involves the participants and the researcher in two ways: there will be a flow of ideas between the participants and the researcher, and among the participants.

In focus group discussions, the researcher takes on the role of the moderator. The function of the moderator is to probe significant points raised by the participants and to ensure that the discussion is proceeding in a meaningful and orderly manner.

The probing role of the moderator is very similar to that of the researcher in an in-depth interview. We can ask participants to elaborate and we can pursue issues to a satisfactory conclusion.

One advantage of focus groups over that of one-to-one interviews is that they enable the participants to stimulate each other. In this way, ideas can be not only sharpened and refined, but also broadened out. To manage this process, you may find the following points useful.

- **Concentrate** - complete concentration is necessary in order to pick up significant points from the discussion.

- **Probe** - probing, such as asking a participant to elaborate on a significant point, is essential. If a participant says that he or she is not happy with the local community health centre, ask for reasons. Were there specific incidents which made him/her feel that way?

- **Provoke** - sometimes you may need to take on a provocative role in order to elicit more detailed answers. For example, you may tell older participants: ‘Yesterday I talked to some older people in the shopping centre. The general feeling was
that public transport in this community is quite adequate and government money is better spent on something else. What do you think? This is better than asking a general question like “What do you think of the public transport system here?” as it helps participants to respond from their own experiences. (Don’t forget to record that you have adopted this procedure to stimulate discussion.)

- **Highlight and Reflect** - you can encourage discussion by emphasising a participant’s contribution and reflecting it back to the group. It is quite likely that when an idea is too sensitive or unpalatable to other participants, it will be glossed over by the group. You can bring the idea to the attention of the group by saying, for example: ‘That was quite an interesting issue that Mr Jones raised. I think his point is that it is unemployment rather than the wrong diet or lack of exercise that is the major problem for families here. What do you think? Maybe Mr Smith would like to respond to this.’

- **Encourage Everyone** - you should try to make sure that every participant in a group has a chance to have a say. The tendency is for one or two individuals to dominate a discussion, and it is difficult to avoid this. You must not be rude by deliberately silencing any one, but certainly you should be aware of people who are not contributing. You can encourage responses from these persons by passing questions to them (as above in the previous point).

- **Elaborate** - you can also do this by elaborating on what has been said and then bringing it to the group for discussion: ‘Now Sarah’s idea implies that we should do away with medical services in the community health centre, because, as she says, the community health centre is better off concentrating on health promotion. This is worth thinking about whether we agree with it or not. I would like to pass the question to the whole group. Start from this side of the table, with Jane’ . . . In this way you make Sarah’s idea the focus of group attention, which she may be too shy to do herself.

- **Look for Clues for Further Research** - keep brief notes on observations made during discussions. Above all, note reactions of participants when key issues are being talked about. These behavioural clues are important supplements to verbal information. They also may suggest the need for other qualitative approaches later on; for example, in-depth interview, or discussions with representatives of certain agencies. For instance, some women participants may appear agitated when talking about domestic violence and
men. Few words may be said, either because they are inhibited when talking about such issues, or they may personally experience such violence, and find it too emotional to talk about it, with or without men present. In such a case, the silence may indicate the significance of the issue, which may suggest how it may be followed up later, either within or beyond the research context.

**Preparation**

It is best to tape-record focus group discussions if resources (and participants!) allow. Don't forget to check the microphone, tape recorder and batteries to prevent a last minute foul-up; make sure the room that has been booked remains available for use and that it is ready. Provide refreshments, child care and transport for members of the group if they need it.

**Simple Notes**

As has been mentioned, it is important to keep simple notes during the discussion, but minimise this to avoid distraction. For the same reason, avoid having outsiders observing the group as they tend to inhibit open discussion.

**Additional Analytical Points**

You should avoid the expensive exercise of employing others to transcribe tapes. Moreover, there is an advantage in carrying through qualitative research from beginning to end by yourself or in your small research team: if you delegate, you may lose the 'feel' of the research, which may be vital for your understanding of emerging issues.

It is sufficient to take down the main points from the tapes, and to refer to your notes of each focus group. Your observations of the discussions are part of the data required for constructing views of the community and of the settings in which they were elicited.

In the report, do not neglect to record in detail the composition of each focus group: socio-economic, age, gender, ethnicity, and any other social or health characteristics relevant to the subject. If you attempt to draw from these data generalisations about the whole community, the composition of the focus groups gives the reader some basis for assessing their 'representativeness'.
Reporting Terminology

Remember, all social research is about getting some indication of the wider social processes taking place in society. This should be reflected in the language we use in the report. Write tentative rather than absolute statements, for example, ‘Older men tend to express a strong dissatisfaction with the lack of regular bus services in the community; but those from higher income groups generally do not find this an issue’; or ‘it is the strong feeling of the women participants that nutritional information should be more readily available to the community’; and so on.

Disadvantages of Focus Groups

The main disadvantage of focus groups is that, as with in-depth interviews, the information obtained is only what participants say they do or believe in. Further, a group leader may draw out opinions and feelings that may be exaggerated in order to make an impression on other people in the group.

That is why we emphasise the importance of data arising from other social circumstances and methods, such as observation of the participants’ reactions in discussion, and your own growing understanding of the community. Other qualitative approaches are therefore helpful, so that your final analysis should reflect the full range not only of the content of the discussions, but of the emotional contexts in which the information was obtained from various sources. All are part of your data.

For example, if most men participants appear (in the focus group) to give full support to special health services for women, in contrast to what we know of how many men in the community seem to feel, the report may read thus:

‘Most men participants appear to give full support to the idea of more health services for women. This conclusion should be treated with caution. It is our experience within this community that proposals to increase services for women, particularly single mothers, has, at least in the recent past, been resisted by many men and, in particular, by male community leaders. It might be that statements by men participants in these focus groups is posturing, i.e. appearing to support women’s issues in front of the (female) moderator - rather than reflecting the full range of their true attitudes.’

Nonetheless, when reporting results of a focus group study, use information that has arisen directly from within the focus group as
the basis for your conclusions. When information reported by participants appears to contradict your understanding of what seems to happen in the community (e.g. derived from observation), sensitively explore this. Each technique yields different information; the aim is to explore the social meaning of that information, with each slab of data related to its methodological source (interview, or focus group, and so on) - not to use one to undermine another.

Conclusion: Focus Groups

Data arising from focus groups can quickly provide a valuable overview of community concerns about a range of topics. This can be assessed by the steering committee and followed up by further research using say, in-depth interviews. Depending on the skill and experience of the researchers, focus group techniques can be adapted to informal group settings with persons who might otherwise refuse to be involved, e.g. 'street kids' perhaps.

Unique obstacles face focus group discussions. When the discussion is not going well, be prepared to replace the group with new participants and hold another discussion. On a more positive note, focus groups can be very useful when the discussion is not forced but flows well. We can probably expect fewer problems in gaining acceptance for this method in health research, as community health issues are of personal concern to most people and they are increasingly being seen as having a community/regional dimension. Many find it satisfying to have their say in a group situation, especially when they are convinced that the research in which they are participating may contribute towards the improvement of services in the community, and a better understanding of the ways social forces shape their health and their immediate environment. For some, it may be a way of linking their concerns to further community action projects, or the formation of a new action group.

Nominal Group Technique

The nominal group technique is a process by which a group of people can clarify their priorities on a selected issue, which encourages the participation of the less assertive members of the group. The process also allows issues to be placed in order of priority.

The following steps are an example of the nominal group technique.
The purpose of the group meeting and its process are explained to participants.

Everyone is asked to record their ideas on separate cards. For example, if the group was considering the needs of children under 5 years of age, a group member may have written on four of her cards: more playgrounds, safer roads with less traffic, more free child care, better immunisation services.

The cards are collected from all members of the group and sorted into categories dealing with similar topics. In the above example these might be: child-care, safer environments outside the home, more accessible child health services, support for parents in their role, facilities for children with special needs.

The topic areas are then listed with the specific needs grouped under each.

The group members are then allowed three votes and can allocate these to the three topics they believe are the most important.

The votes are then counted and the topics placed in order of priority.

Conclusion: Nominal Group Technique

The main advantages of this process include the involvement of the more reticent group members, an outcome that reflects the opinions of the whole group, and its ease of operation. Also, it can be conducted relatively quickly (approximately 2-3 hours should be allowed). The rules for running the groups, such as ensuring that participants are relaxed, are much the same as for focus groups.

The main disadvantage is that it only allows for minimal exploration of those issues that emerge as the most important; also some group members may have good reasons for regarding particular issues as the most important one, but which, in the group process, do not rank highly.

The Delphi Technique

This is a method of soliciting and aggregating the opinions and knowledge of a diverse group of ‘experts’ (Delbecq, Van de Ven & Gustafson 1975:84-85). It involves a series of questionnaires, usually distributed by mail, the first seeking a response to a broad question. Each subsequent questionnaire is built on the responses
to the preceding questionnaire and the process stops when sufficient information has been obtained, or consensus reached.

The Delphi Technique has three main features.

- None of the ‘experts’ being surveyed know who else is being surveyed. This reduces the effect of dominant individuals as it prevents undue influence on panel members and releases respondents from inhibitions.
- Controlled feed-back entails a summary of the results of the previous round being channelled back to the participants.
- The statistical group response ensures the opinion of each respondent is represented and reduces group pressure for conformity.

**Conclusion: Delphi Technique**

This technique requires three conditions for success:

- adequate time must be allowed for response to, and feed-back from, questionnaires;
- participants must be capable of good comprehension and writing skills;
- the group must consist of self-motivated people who are used to articulating their thoughts on paper, as there is no contact among group members to stimulate motivation.

**Group Techniques: A Concluding Remark**

Group discussions, compared with in-depth one-to-one interviews, can be unpredictable. It is difficult to know beforehand how participants (however carefully we select them) will interact with each other in a group where they are asked to talk about serious social issues. We have mentioned the problem of posturing; that is, the tendency for participants to present a certain image of themselves in front of others; or there may be personality clashes when some people do not get on well with each other. Also, it may be difficult to ‘break the ice’: having refreshments on hand is not just a courteous gesture, as it also encourages relaxed participation and helps to get people over their initial nervousness. Commercial market-research groups even provide alcohol, as well as tea, coffee, and juices, for this very reason.
CHAPTER 5 - An Example of Qualitative Research

Qualitative research methods were used by the SCHRU in a local area to supplement (and compare and contrast with) information derived from census and other official sources.

The Christie Downs Project

The aim of the Christie Downs project was to set alongside quantitative information concerning the Local Government Area of Noarlunga (primarily from the ABS Census), additional qualitative information gained from residents and workers in the area. The purpose of the study was to find out if there was any basis for the widely-expressed opinion that the people of the area had a low quality of life.

The qualitative methodology for this project involved a combination of observation in the area, interviews, a questionnaire (used in one Housing Trust area, n = 60) and the compilation of a fieldwork journal.

Those interviewed were of the following categories:

- community members, e.g. members of a Housing Trust Residents' Group;
- staff from local churches;
- key informants, e.g. the principal of a local school;
- staff of government and non-government agencies, e.g. a youthworker.

Although the interviews were informal, brief notes were taken at each session.

At frequent points during the research, an assessment was made of material gathered, alerting the researcher to recurring themes. These themes were fed into subsequent interviews to gauge responses. The expressed views of some service providers were explored in relation to those of other service providers, and of residents.

When the fieldwork was complete, the notes were analysed and restructured in terms of dominant themes. Then the fieldwork
journal was explored to see to what degree the perceptions it reported as representative of various groups, were in harmony with those of the original informants.

Key informants were then sent extracts of the text (which included their own comments) in order to gain approval for their use and to make amendments where necessary. A number of informants made changes that (they claimed) improved the accuracy and clarity of the comments that had been noted. Some professionals who worked in the area asked for comments to be deleted or fundamentally modified, as they were unhappy that views expressed in the context of informal discussion should appear in print, even if anonymously.

One informant challenged the researcher’s expressed viewpoints and pre-conceptions as noted in the journal. This highlighted the perilous nature of trying to understand and describe a community’s perceptions, even with some personal experience within, and empathy for, those values expressed by the community representatives, residents, and others.

A copy of the manuscript was also given to one Christie Downs resident for checking the overall emphasis. This resulted in qualifying and correcting statements on specific topics but little in the way of helpful critical comment of the substantial results.

An illustration of the application of qualitative techniques for the above project is provided below.

**Women and Isolation in Christie Downs**

The following are comments on, and extracts from, the SCHRU report (Traynor 1990) which discussed women and isolation in Christie Downs. By combining the technique of observation in the local area, interviews with health and welfare workers, and informal discussions held with local residents who had experienced various forms of isolation, a deeper understanding of the problem of isolation amongst women in this area was obtained.

---

21st September 1989, 8.30am. In the Colonnades
I see a woman I think I have seen before. She is young, overweight, sitting opposite the record store, crouched, looking at the floor with her head in her hands. Beside her on the bench her handbag lies open with cigarettes and a lighter lying on top.
Nearly every service provider approached believed that isolation was a serious problem in Christie Downs, particularly for women with young children; indeed, it was felt to contribute to the stress they experienced. Local mothers of school-aged children endorsed this view, although other residents without young children apparently did not.

Simon, a youth worker, offered a background to the situation for some families.

*One cause of unhappiness is social isolation. Many residents emigrated from England, and from the poorer North in particular, with great hopes for a new future.*

These families left behind well-established friendship and family networks. He went on:

*Some immigrants discovered that although the weather may be better and their house at ground level with a plot of land around it, they still had no job. Only now they had no friends or relatives either.*

Simon linked what he saw as a high degree of family breakdown to this social dislocation. Many explanations were given for this isolation. Michael, a social worker, described how some families in Christie Downs are ‘in transition’. They have recently moved from interstate or overseas and have not yet established close friendships. Some may have family in distant parts of Adelaide or interstate who are unavailable for day-to-day support, or who cannot afford to travel frequently to the area. Some women have moved there to escape marital conflict, and many people move to South Australia because it is seen as a cheaper housing State.

**Lack of Social Support - Culturally Prescribed?**

Michael felt that:

*There is a cultural practice of keeping distant from one’s neighbours or even having no contact at all with them.*

Raylene, from Child and Adolescent Family Health Services, supports this perspective:
Women tend to take on a traditional role, servicing partner and children. Many have no nearby family to relieve the burden of child care. Some, who used to work in the city, lose contact with old work friends after they have had children. For people in other suburbs, Christie Downs is much too far away to maintain friendships there.

Also, she feels, some women find it difficult to get away from their baby or child. This may be due to circumstances but also, possibly, to an unwillingness to step outside the security of a known role.

They tend to be extremely hesitant about 'imposing' on neighbours with requests for even short-term child minding.

Residents' View: The Problem of Isolated Women

Residents of Christie Downs, though they view Christie Downs as friendly, described a range of different experiences. One young mother explained that it would be a typical experience for Christie Downs people to bump into large numbers of friends on every excursion from home. However, another woman said:

It's safer to be outside the house than inside. You could lie dead on your floor and no one would know.

It seems likely, therefore, that some people do not make these excursions from their home. Many women are mothers whose children are all at school and whose husbands work long hours. After years of a home-based role they have lost the confidence to leave their houses. They tell of an addiction, not to drugs but to:

T.V. soaps. They don't go out because they don't want to miss the next episode. You can spend all day watching one after another. And if you're forced to go out you can video it and catch up later.

However, these people testified that there is hope. They and other mothers accepted their children's school's invitation to become involved in a range of daytime activities. They describe this involvement as 'life-saving'.
Conclusions

When you do qualitative research you are not necessarily looking for a commonality of opinion, nor for the 'truth' about any particular matter. Rather, you are using several methods to obtain information about that particular matter and each method throws its own particular light on that matter. You have to be alert to the many factors that illuminate the 'why' of what is being revealed.

Comments arising out of an in-depth interview should be carefully considered as such, especially when set alongside comments that arise from, say, a chance meeting with someone at a bus stop for a few fleeting minutes. Both may be significant. Both have their place in qualitative research. Both are legitimate in their own right, and both are fundamentally different forms of information.

This does not mean that you over-emphasise the situation in which your data was generated to the detriment of wider social concerns. Precisely because the respondents' particular descriptions or behaviours are inseparable from their wider social setting, these concerns will also beckon closer investigation. In this way, for example, the 'isolation' which became a focus of the SCHRU report, reflects community beliefs about privacy and the need for companionship, about crime and social order, about 'neighborliness', the alienation felt by immigrants, and so on.

These are all important aspects of social health in Christie Downs - and all highlight the proper place for, but limits of, official quantitative data.
reporting back and planning

Section Five
SECTION FIVE: Reporting Back and Planning

1. Reporting Back
2. Needs Assessment and Priority Setting
CHAPTER 1 - Reporting Back

You have analysed your various forms of data and have in front of you a range of types of information: summaries of meetings with workers, community groups and community members; your observations; computer frequency print-outs displaying numbers and percentages from your survey; census data and perhaps other information as well.

What Now? Writing a Report

The aim of report writing should be to make your findings as accessible as possible to a wide range of people without compromising the depth and quality of your information.

At the beginning, with all the above paperwork stacked up on your desk, this can seem like a daunting task. Below are some hints to help you organise the data into a meaningful report that people will want to read.

The Form of the Report

The form of your report depends on the audience. Few people other than researchers will read a lengthy, detailed report. If you want community people and busy workers to read it, your report will have to present information in an appealing and easy-to-read format. Illustrations, photographs and cartoons can be included to achieve this.

For a small or local assessment of needs, the method, findings and recommendations might best be presented as news sheets under those headings.

More ambitious reports usually contain an Executive Summary, Recommendations, an Introduction, Results, and sometimes an Appendix.

Some researchers have a separate section for their methodology, others report it in the Introduction. What you do depends to a great extent upon your intended audience. If you want a wide audience for your reports, provide an overview on the methodology in the introduction and publish a separate information sheet with the details of your method for those who want this information. Many people will not be interested in technical details.
The Executive Summary

This is a summary of the whole report. It is usually one to two pages long and includes the main points from the Introduction, the Recommendations and the Results.

The executive summary provides readers with an understanding of the research, the main results and the recommendations, without them having to read the whole report.

This does not mean that it takes the place of the rest of the report but many people who are interested in what you have found out do not have the time to read all the details.

The Introduction

In the Introduction you will need to:

- define the terms you use;
- describe the overall setting in which the research was done;
- explain the reasons for the research and its goals;
- state who financed it;
- describe the values that underpin the report;
- describe the methods used;
- list the sources of your information;
- describe any weakness in your methodology of which you are aware.

This final point is important. If your are aware that your report can be criticised because of a weakness in the method, or because of external factors beyond your control, the Introduction is the place to clearly state this. Few people have the funds to do a perfect piece of research. Admitting to the gaps in the information or other weakness at the beginning of the report will give it more credibility and will allow readers to judge at the outset the nature of the information they are receiving.

If you have a separate section for Method, then you will not have to go into as much detail about the methodology in the Introduction. In journal papers it is also more usual to leave the discussion of problems with the methodology to the final section of the report, usually labelled Discussion.
Recommending or Ideas for Action

Not all reports have Recommendations. Three of the four reports from the Marion, Brighton and Glenelg Community Health Needs Assessment had 'Ideas for Action'. In this section you pass on suggestions that will address the needs that have been identified.

Recommendations or Ideas for Action can come from a number of sources: the steering committee, community workers, a literature review, community views, or they can arise out of your analysis of the data.

Sometimes needs may be identified without the researchers having any suggestions as to how to meet those needs. It is not the researcher's responsibility to have a recommendation for every result. As long as the research is clear about the needs and problems of the community, it is reasonable to expect others in the community to discuss the results and work on solutions.

Results

This will form the bulk of your report and contain all that you have found out from your research consistent with its original goals and aims. The results of the report will contain facts about the community you have researched, it may include some figures and percentages, and perhaps charts and graphs.

To make the results as easy to read as possible:

- set them out clearly;
- use headings and sub-headings wherever possible;
- keep paragraphs short;
- leave lots of space on the paper - too much information on a page can be intimidating to readers;
- use tables and charts wherever possible to report figures or percentages;
- use cartoons or photographs to break up your pages (see Appendix 5.1).

Acknowledgements

Make sure that you give a list of steering committee members in your report and acknowledge the help you have been given by various agencies and people.
Reporting Data

Percentages, Numbers and Decimals

When do you use percentages? When you can generalise from your sample to a population.

28.6% of mothers planned to continue breast feeding until their child was between sixteen and eighteen months old.

Putting figures into percentages suggests that a general statement is being made that is true for a particular population.

In the case above, the sample size was only 14. As it is not possible to generalise from 14 cases, it would have been more accurate to state 4 out of 14 women said they planned to continue breast feeding.

If you have found that 200 out of a sample of 375 arthritis sufferers felt there was a lack of sympathy from friends and relatives, you would report this as 53%; if, however, in a group discussion with 10 arthritis sufferers, eight had said the same thing, it would not be acceptable to put this in percentage form. Instead:

The majority of arthritis sufferers in this group (8 out of 10) said they felt there was a lack of sympathy from relatives and friends.

After this you would follow with more data, either supporting or conflicting with your comments, gathered from community workers or community members.

Decimals

If you have done an exhaustive survey of all diabetics in a small town, say 300, you could report the findings in decimal form. If 227 of the 300 had reported difficulties with chemist’s hours it would be appropriate to report this as 75.7% of diabetics.

However, if the 300 people interviewed were only a sample from a city with a population of 4,000 diabetics then there is disagreement whether the decimal should be reported or not.

This is because surveys have an error range. In this Manual we have suggested a sample size based on a 5% error range. This means that
a finding of 75.7% is really a finding of between 70.7% and 80.7%. To report the range each time is too cumbersome so we tend to ignore it with the overall understanding that survey figures are within a given range. To include a decimal does suggest a degree of certainty which is not present.

Reporting Quantitative Data

Quantitative data can be presented in either of the following ways, singly or in combination.

As a table:

<table>
<thead>
<tr>
<th></th>
<th>Non-Strenuous Exercise</th>
<th>Strenuous Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MALE</td>
<td>FEMALE</td>
</tr>
<tr>
<td>Not at all</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>1 - 2 per week</td>
<td>31</td>
<td>40</td>
</tr>
<tr>
<td>3+ per week</td>
<td>36</td>
<td>41</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Figures may not add up to 100% because of rounding.

In statement form:

Whereas almost half the men (46%) engaged in strenuous exercise, less than a third of the women (27%) did.

When to Write and When to Chart

Information from computer print-outs can be reported in a table, graph, chart or in sentence form. Charts may be column-charts, bar-charts or pie-charts (see examples on the next page). When there is a table or chart presentation, usually you will need to make some comment on the data, summing up an overall trend.
Bar Charts:

Figure 12: Frequency of Non-Strenuous and Strenuous Exercise Amongst Males and Females 17-24 Years

Non-Strenuous Exercise

- Male (n=84)
  - 3+ Times a Week: 41%
  - 1-2 Times a Week: 33%
  - Not at All: 36%

- Female (n=109)
  - 3+ Times a Week: 40%
  - 1-2 Times a Week: 18%
  - Not at All: 31%

Strenuous Exercise

- Male (n=85)
  - 3+ Times a Week: 46%
  - 1-2 Times a Week: 25%
  - Not at All: 28%

- Female (n=109)
  - 3+ Times a Week: 45%
  - 1-2 Times a Week: 28%
  - Not at All: 27%
Prose reporting is appropriate when there are only a few results you want to highlight, for example:

...forty percent of people were sick or unwell in the past two weeks...

When there are a number of results you want to report, a table or chart is easier to follow.

Compare the two methods of presentation in the boxes below.

35% of women said they liked the neighbourhood while only 20% of men did. 25% of women said they didn't like the neighbourhood and 40% said they neither liked nor disliked it. 10% of men said they didn't like it, while 70% of men said they didn't like it or dislike it.

Of women with children under 18 living at home, 28% were satisfied, 36% were dissatisfied and 36% were neither satisfied nor dissatisfied.
TABLE 2: NEIGHBOURHOOD SATISFACTION (n = 375)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>28</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>17</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Neither sat. nor dissatisfied</td>
<td>55</td>
<td>70</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Women had stronger opinions on neighbourhood facilities than men, with a large majority of men neither satisfied nor dissatisfied with facilities (Table 2). Although over a third of women were satisfied with neighbourhood facilities, a significant minority (one quarter) were dissatisfied. An analysis of the data by family type showed that the highest level of dissatisfaction (36%) was amongst women with children under 18 years of age living at home.

The same data are presented in both boxes. In the first box, the results are presented with no attempt to summarise them into a meaningful statement. All the work is left to the reader, who has to sort through the percentages to get an overall picture. In the second box there has been an attempt to draw the overall picture with the details presented in table form for readers who want them.

Sometimes you may wish to use a variety of methods to present the same data. A simplified graph may provide an overall picture, with tables presenting the data in greater detail.

Ways of Reporting Qualitative Data

Qualitative data are usually reported in sentence form. When quotes are used they are usually indented and highlighted. Graphs and charts are usually not appropriate for qualitative data.

The overwhelming response from students in years 9 -11 in Marion High School to a question about young people's needs, was that young people in the area needed a place to go. This reply from a year 10 student clearly puts the students' point of view:

'I think we should have an area where all us teenagers could hang out.'
Quotes illustrate the data, and they have the added advantage that they also break up the usual paragraph structure to make the page visually attractive and bring your data to life.

Reporting the Information to the Community

Some very good reports lie on shelves gathering dust and never achieve anything.

The researcher's job does not end with the presentation of a report. If action is to be taken, the report needs to get to those people who are in a position to take such action.

For those working within a community health centre, there is a ready-made forum for action on the report.

However, it is most likely that not all of the needs that emerge from the needs assessment can be satisfied by the local community health centre. Other sections of the community should take action if the needs identified by the report are to be addressed. For this to happen, the report needs a wider circulation than the community health centre.
As we mentioned before (see Section 2 Chapter 2 on Research Ethics), the researchers also have the responsibility to return the information collected to the community in which it was collected.

What are the ways of getting the information and the recommendations out into the community?

**Networks**

If you have a broad range of people on your steering committee, they can keep their agencies or community groups in touch with the progress of the research. This informal networking is an essential aspect of spreading and sharing the information you collect. The people who have most knowledge of the data, and of the process of collecting it, are the most likely to act upon it.

**Video**

Video provides a suitable medium for reporting back data from studies to any audience. It is particularly good for people with low literacy skills. An excellent example of the use of video for this purpose was provided by the Central Australia Aboriginal Congress which used such a medium to present findings of the Uwankara Palyanyku Kanyintjaku Environmental and Public Health Report. Making a video is not cheap but it can be a powerful and appropriate method of communication.

**Launching the Report**

For significant reports, a public launch can be organised where press, community members and people who have been involved in the preparation of the report are invited to an official ceremony. Reports are then available for sale or distribution after this date.

A local identity, a local politician, the Minister for Health or Community Welfare, or a similar appropriate figure may be approached to launch your report. This gives publicity both to your report and to the figure involved, and brings your report to the immediate awareness of someone who may be influential in having the recommendations of your report implemented.

Invitations to such a launch should be sent to the steering committee, everyone who helped with the report, and local people and workers who you know will be interested. To encourage the attendance of other members of the community, the following ideas have proved helpful:
• put an advertisement in the local paper as we did for the launch of the Marion, Brighton and Glenelg Community Health Needs Assessment;
• depending on funds, invite respondents or interviewees, or a sample of them;
• put up notices around the community;
• send out media releases to the press in your area.

Press Releases

If your results are of interest to your community, the local newspaper will be interested in printing them.

You will need to send the press a news release which is a very brief statement of the results that are likely to be of the most interest to the community. Provide a phone number and contact name. Make sure the person named is experienced in dealing with the press. If the paper intends to run the story, a journalist will ring and ask you for more details.

For those employed by the South Australian Health Commission, the Public Information Unit will help you write a press release. Other health departments may have similar resources. If you decide to write your own, here are a few guide-lines:

• keep it brief;
• keep your paragraphs short (six lines is a reasonable length);
• highlight your major findings;
• include direct quotes from the researchers;
• briefly explain why, when and where;
• provide a contact number and person.

Be careful you don’t sensationalise your results, as you may end up with more publicity than you bargained for. If what you found is contentious, or is likely to upset a group of people, discuss it with them before the press release goes out so that they can prepare a response.

In Appendix 5.2 is a copy of the press release we sent out about the Youth Report from the Marion, Brighton and Glenelg Community Health Needs Assessment.
A Community Health Issues Day

For the Noarlunga Community Health Needs Assessment, we publicised the research findings and involved the community with a Local Issues Day.

Residents of Noarlunga and local health workers were invited to discuss the issues that had emerged from the report. One hundred and fifty people came to the public meeting to discuss the results and to take part in the workshops that were held on such issues as Mens' Health and Family Care for Disabled People.

In Appendix 5.3 is a copy of the invitation to the Health Issues Day.

Setting up an issues day requires much time and effort. Obtaining a good community presence can present difficulties. You should provide transport for some people and in most cases you will need to provide a creche, and substitute care for people who are looking after elderly or disabled people.

Presentation to Councils

Local Councils are always interested in information about their area and you will find that most Councils, or Boards of Health, will be responsive to a request from you for an opportunity to present
your results. In many cases, Council officers will already be familiar with your results if councillors and Council officers have been members of your steering committee.

Schools

Schools are often interested in your research results, especially if they are pertinent to young people. The best way to approach a school is to send a copy of your report with a covering letter to the Principal asking if you may present the highlights from your report to the students.

Presentation to Community Groups

Be prepared to make as many presentations as possible. This is a good way of spreading information, especially as community groups can set up their own committees to help initiate action based on results, and can be of enormous help in achieving change.

The Marion, Brighton and Glenelg Community Health and Social Welfare Council examined the Marion, Brighton and Glenelg Community Health Needs Assessment and formed committees to seek ways of implementing the Recommendations and Ideas for Action of the four reports. The Marion Forum took similar action.

Posters in Public Places

You may like to set up a poster presentation of your findings which can be moved around the community. Libraries usually accept such presentations, and you will find that shopping centres are also very accommodating. Depending on the nature of your research, you may like to consider setting up posters in schools or in senior citizens clubs.

How Long Does Reporting Back Last?

There is no easy answer to this question; however, as a broad principle, the longer the better. The information you collect is likely to be a resource for some time to come. The reports from the Noarlunga study undertaken by this unit are still being requested five years later. The core of your information is likely to remain relevant for some time, even though it will need to be interpreted in the light of changing circumstances.
CHAPTER 2: Needs Assessment and Priority Setting

Introduction to Priority Setting

Maria and Nikita were concerned about the program balance at the community centre where they worked. Were the programs they were running really assisting their community as much as they could be? And were the programs they were currently running consistent with the aims of their Centre?

Maria and Nikita obtained funds to do a needs assessment. They followed the Manual step by step and, at the end of six months, had identified five needs in their community.

Then they sat down with all the other workers in the community health centre and, on the basis of the results of the needs assessment, they drew up a list of priorities and goals for their Centre.

The workers identified groups they wanted to target, they agreed on the types of programs and interventions that would be in keeping both with the needs of the target group and the philosophy of the Centre, and they drew up a list of programs that would improve the health of their target group.

Next, they revised established programs, deleted some and added new ones. They ended up with an integrated approach that incorporated the values of the Centre and targeted the needs that had been identified.

While some community health workers may see their own Centre reflected in this story, to others it will seem no more than a wishful fantasy.

The reality for many community health centres is that there are difficulties to priority setting, even once the information about the community's needs is available.

In 1989, the Research Unit ran a workshop for community health directors in South Australia on Effective Priority Setting.
This chapter includes some of the results of this workshop, along with accounts of how priorities are set at local and regional levels.

Results of Priorities Workshop

The workshop identified four major obstacles to effective priority setting and possible solutions.

Working Through the Process.

The most frequently cited barrier to effective priority setting was the difficulty in actually going through the process of setting priorities.

This overall question 'How do we do it?' resolved into several specific questions.

- Where do we get the information to set the priorities?
- How do we develop a framework for setting priorities?
- Who sets the priorities?
- How do we get agreement on priorities, especially when professional interest causes conflict?
- How do you decide what to cut out?
- How do you overcome resistance to cutting established programs?
The suggestions that came out of the workshop for addressing these questions were:

- training community health workers in priority setting methods and techniques;
- training community health workers in the use of census data and ABS publications (e.g. Social Health Atlas), local council information, and research information;
- more training in groups that are not professionally-based i.e. multi-disciplinary groups.

Resources Available for Priority Setting

For many of the community health centre directors, the bar to effective priority setting was simply a lack of resources.

Directors thought that within their own Centres:

- there was insufficient time to consult adequately;
- there were already too many meetings;
- there was a crisis orientation - the workers were constantly dealing with problems that demanded immediate action, leaving no time for planning;
- workers felt that the needs already being addressed were of sufficiently high priority;
- there were insufficient funds or workers to follow up on the priorities after they were set.

Possible solutions suggested by the participants of the workshop were:

- put effort into obtaining more funding;
- ensure Centres have strong internal and external support systems operating;
- establish a coherent ideology for the Centre as a basis from which to work;
- work towards manageable goals;
- establish a set of long-term goals;
- ensure that any acceptance or rejection of ideas is on a rational basis;
- hold a regular and ruthless review of activities;
- recognise personal limits and the limits of the Centre.
Managing Change

One of the problems identified by the directors at the workshop was managing change. Specific problems included:

- resistance to change because of conservatism and lack of creativity of people within the group;
- concern with the implications of change;
- the difficulty of getting agreement on priorities;
- the difficulty of making choices;
- a tendency to take on cases that present themselves, rather than pursuing the ones that have emerged through some form of needs assessment analysis.

Solutions that were suggested:

- provide workers with full and honest information about the priority setting process, and the problems that arise in using the process;
- obtain workers’ commitment to the goals and outcomes;
- discuss uncertainties and disagreements, and work these through in a group;
- establish clear decision-making structures that involve all workers and are agreed to by staff;
- acknowledge that change demands energy;
- strive for gradual rather then overwhelming change;
- provide feedback to staff;
- encourage staff development and skill training;
- develop conflict resolution skills.

Structural Impediments

Some of the participants in the workshop felt that blocks to effective priority setting were raised by the structures within which they worked. These fell under two headings.

a) Bureaucratic

- Government bureaucracies and Boards of Management.
- Professional interest groups which have vested interests and clearly delineated roles - they may also manifest resistance to suggestions of accountability to other professionals, let alone to the community.
- Lack of community representation.
b) Ideological

- Differences of opinion on priorities arising from differences in ideology and values.
- Political agendas of those outside the Centre.
- Doubts as to the value of the process and consequent reluctance to provide time for it.

Overall there was a feeling that there was no framework available for decision-making and information-sharing in the community health setting.

The impact of these structural impediments was felt most strongly following staff vacancies, and when allocating resources and making decisions that affected services.

Suggestions for overcoming the structural blocks to priority planning were:

- restructure Boards so that they obtain more support from the government bureaucracy, the community and the Centre;
- look at broader staff development;
- make sure the Centre is accountable to the community;
- develop priorities and strategies with workers;
- establish team structures based on priorities, e.g. breast cancer, traffic accidents, teenage suicides;
- institute cross-professional and multi-disciplinary peer review.

When workers have doubts as to the value of the process, it is important that they are given the opportunity to see how the philosophy and goals of the Centre can be met only through a rational decision-making process that sets priorities, and that this cannot be accomplished through ad hoc programming.
Priority Setting at a Local Level: Accounts from Three Community Health Centres

Community health workers at three Centres in metropolitan Adelaide described similar processes for setting priorities. The following diagram gives an overview of the process they described:

| Preparation | Data gathering, listing of issues and previous priorities; funding and resource issues. |
| Planning and Ranking | Criteria for ranking of issues. |
| Developing Strategies | Issue-centred working groups. |
| Monitoring and Review | Weekly, monthly and half-yearly progress reports; budget updates. |

Tea Tree Gully Community Health Service

This Centre has an annual Planning Day. Workers in this Centre are organised into four teams, focussing on different sectors of the community. Each team draws up lists of priorities, using data from a variety of sources, which are circulated to its Board of Management. The Board may add further issues and finally a research/project officer draws up briefing notes for the Planning Day. The then-Director, Paul Laris, continues:

Our aims for a planning day were to rank issues for each team and to decide which issues we would definitely target for 1989. To do this we spent a one hour session on each team’s issue list. During this time the issues were ranked by a simple voting process according to the following criteria.

The health importance criterion is concerned with how debilitating the effects of the issue are on how many people for how long. It is also important to acknowledge that some issues will have flow-on or indirect effects which may be even more deleterious to health than their direct effects.
Community concern is an important factor because it gives some indication of the degree of support or otherwise for action on particular issues. As well as the wishes of the community of users and residents, the interests of all stake-holders, including the government, must be taken into account.

Relative need is an extremely slippery concept but there are some essential questions: what resources are already targeting this issue? Are they sufficient? If there is a shortfall, how large is that shortfall?

Then we asked ourselves whether or not any intervention by our agency is likely to be effective. While we do not know at this stage exactly what our intervention might be, we do have some idea of the range of possible interventions available to us. We need to ask whether the scale of it is within our resources, whether we will be able to set achievable and evaluable targets and whether someone else could do the job better.

Finally, the group was asked to estimate how many of these issues we could realistically take on, and some had to be set aside. The result was a set of priority issues which were referred back to the teams for the development of strategies. These in turn became program plans which are reported on and reviewed at our monthly team meetings.

Dale Street Women's Health Centre

Leslie Shorne, Medical Officer at this Centre, describes a slightly different process. Although, like Tea Tree Gully, the ranking of priorities is carried out by consensus at a planning meeting, their planning is carried out on two days, separated by a number of weeks. This gives staff and Management Committee members an opportunity for reflection on the outcome of the first meeting.

At Dale Street, preparation for the initial meeting involved the gathering and presentation of a large amount of information. This included placing the work of the Centre into the context of the whole Western region and viewing it against State and national priorities and campaigns, a review of funding issues and summaries of workers’ skills, interests and aptitudes. A brainstorming approach was used and six possible priority issues emerged. Over the next three weeks these were developed into proposals and circulated to all staff and committee members. On the next planning day, these priorities were ranked.
Each proposal was discussed in turn, under the following headings.
* Benefits to the community, to our clients, to the Centre.
* Burdens to the community, to our clients, to the Centre.

Then workers were led by an outside facilitator in a guided fantasy through a chosen proposal.

This enabled people to project emotional concerns and issues, as well as to consider possible outcomes and developments in the coming year.

Then each priority was ranked in terms both of its importance and feasibility using the following criteria:

**Criteria for Importance**
* Incidence/prevalence
* Severity
* Nature of effect (acute, etc.)
* Need group
* Cost to community (financial and social)
* Can it be viewed in a primary health care context?
* Prevention of future problems

**Criteria for Feasibility**
* Is the community asking for it?
* Is this a preventive program?
* Is there community participation?
* What are the equity issues?
* Does this program direct resources to an already disadvantaged group?
* Do we have staff available?
* Is the target readily approachable etc.?
* Can we get money for it?

Each person then ranked the project proposal in order of priority 1 to 6. Using this method, two projects were chosen as priorities. The progress of these projects were reviewed six months later. In addition to this review, priority work groups reported back at weekly staff meetings.
Dale Street staff consider that the **advantages** of this process include:

* [The process] is not static and therefore there is less chance of resistance from staff etc. to possible changes to the procedure.
* Using an outside facilitator . . . frees the whole group to become actively involved.
* As a joint management committee and staff procedure, it offers an opportunity to work together and to gain an outside perspective on community views.

And the **disadvantages**:  

* Workers can respond only to priorities within the guidelines and worker commitments already set by community health centres and the expectations of the South Australian Health Commission.
* Responding to a priority need often snowballs into increased demands on service delivery.

**Eastern Community Health Service**

Dianne Jones, then-Director of the Service, reported that decisions regarding priorities and focus are made from the following criteria:

- community health equity principles;
- how far other services are addressing particular issues or working with certain target groups;
- what is realistically achievable using available resources.

**Program planning, development and evaluation processes have been established within the organisation to ensure that there is adequate opportunity to ask the hard questions about whether we do what we do for the right groups and issues, and whether we do it well enough and cost-efficiently enough as a regional organisation with district centres.**

Each Centre reviews its annual operations towards the end of the calendar year and, with Advisory Committee members' involvement, develops the work plan and sets priorities for the next year based on what has been delivered (and how effectively) in the year ending. The Annual Plans are forwarded through a Program Review Committee to the Board of Directors for approval and feedback - to be taken on board for the next round.
Ideas for programs which arise during the year, extra to the Annual Plan, are, after being discussed with community members, other staff, Advisory Committee members and the Centre Co-ordinator, forwarded to the Program Review Committee for discussion, approval and feedback. The membership of this Committee comprises a Research Unit representative, Centre Co-ordinators, Eastern Community Health Service, Resource/Project Officer and the staff concerned, which varies depending on the proposals . . .

Program evaluation methods to be used are also considered at this time . . . and each program is evaluated by the Program Review Committee. Two programs per Centre are evaluated in more detail and presented to the Board each year when the Annual Plan is presented, along with summary information regarding service use, service effectiveness and implications.

The Board also receives regular monthly statistics reports from the Community Health Statistics System regarding reasons for attendance, kinds of groups and community initiatives happening, and numbers of participants . . .

This Service's priority-setting demonstrates the cyclical nature of planning and evaluation as integral to priority setting.

Priority Setting at a Regional Level: Two Accounts

The Healthy Cities Project, Noarlunga

The Healthy Cities Project Management Team took as a starting point the WHO's Healthy Cities general objectives and redefined these into the following working objectives, to which specific strategies were linked.

In 1984-5, the Southern Community Health Research Unit conducted a community needs assessment in Noarlunga, and the resulting report (Apathy or Action, referred to elsewhere in this Manual) became a key reference document for the Healthy Cities Noarlunga Project. The project was therefore based upon a sound assessment of local needs. Its objectives were:

To involve government agencies, non-government organisations, and other sectors in the development of local health policies and actions which seek to establish a social, economic and physical environment conducive to health.
To implement the Healthy Cities Project in a way that defines and promotes equity of access to the resources necessary to maintain good health and improve poor health.

To increase community awareness of a social perspective on health, in particular of the social determinants of illness.

To facilitate and support community participation and action on social health issues of local relevance.

To encourage the re-orientation of local health services towards health promotion.

To implement and evaluate demonstration projects focussing on intersectoral co-operation and community involvement.

To evaluate the process and the outcome of the Healthy Cities Project at the local level using a common national framework.

Using repeated community consultation, in the form of Visions Workshops, which attracted up to 300 people, the Project Management team committed itself to supporting priorities that arose from the community rather than impose issues upon it.

One of the essential elements in developing Noarlunga as a Healthy City is to engage the community in exploration and discussion of their images, expectations and desires for the future... 

In short, Healthy Cities... aims to empower local communities by fostering, nurturing and facilitating positive social activity. But the Visions of Noarlunga Project has a very important additional component. The residents, in discussing the future of their community, are invited to be prescriptive rather than descriptive. That is, they are asked to consider what Noarlunga might be, rather than what it is (Healthworks, August 1989).

The result has been Healthy Cities initiation or espousal of a range of healthy issues, including the Clean Water Campaign and The Greening of the South.

The Annual Western Regional Planning Conference (AWRPC)

Adelaide’s western suburbs are characterised by higher levels of most illnesses, lower incomes and less adequate services than many other parts of the metropolitan area. They are home to many people of a non-English-speaking background, particularly recent
arrivals, and contain an uneasy mix of older industrial and residential development.

AWRPC grew from the desire of a group of primary health care workers to improve co-ordination of, and participation in, services in their area. It attracted funding from the SA Health Commission for a part-time project officer to work on the project for six months.

In 1990, AWRPC organised a two-day conference to set their year's priorities. Conference participants were invited from a range of backgrounds: from health and other related agencies, including representatives from local government, the State Transport Authority, and from the community via word-of-mouth, the local newspaper and the District Health Council. A pre-conference meeting was held for and by doctors to encourage their attendance.

A background booklet was sent out asking all participants to provide, prior to the conference, two issues: one that concerned their agency, where applicable, and one that concerned them personally. A steering committee, made up of representatives of a number of major agencies and a community member, drew up a short-list from these issues. There were four pre-selection criteria.

- Is there likely to be popular support for this issue?
- Is this issue a long-standing problem?
- Will inter-agency co-operation be maximised in solving this issue?
- Will solving this issue produce positive flow-on effects to other issues?

Using these criteria, a short-list of eight issues was produced.

**The First Day**

The conference was organised into a series of workshops with roughly eight people in each.

At the first workshop, each group was assigned workers from different agencies and professions to provide a variety of viewpoints. The aim of the session was to re-acquaint participants with the principles of Primary Health Care. Group members were to ask themselves what health-based initiatives they saw that worked well, and why.

Membership of the second workshop was organised to bring together individuals from similar interest groups. These included women's health, aged care, disability, and Aboriginal and migrant
health. These groups were given the task of setting goals, objectives and strategies for their particular issue - all in two hours!

At the end of the day, everyone was provided with a copy of every group’s goals, objectives and strategies.

Six working days later . . .

The Second Day

With time to reflect on the previous week’s proposals, participants returned with ideas for revisions. Individuals then presented these proposals and each group pitched for its own interest. Again, every participant received a copy of every proposal.

The final workshop was a voting exercise. Groups were again organised with mixed membership. Each group had a list of the issues and ten dots with which to rank them in this example of ‘Dotmocracy’. Three issues were chosen, and conveners for a group to work on each were nominated.

The Conference steering committee was aware that choosing priorities was a meaningless exercise if there was no follow up activity. To help guide its action, four questions were asked.

- What do we want?
- How can we get it now, without extra resources, by better co-ordination?
- How can primary health care be improved, with extra resources from the SA Health Commission? (A recommendation concerning these priorities was sent to the SAHC.)
- What strategies can we pursue so that non-health agencies, for example the Department of Environment and Planning, can take notice of these priorities?

Although agencies committed themselves to support three issues, a number of other special interest groups were formed at this conference, fulfilling a conference aim of ‘network creation’.

In summary, this chapter has identified three principles of priority setting:
* the nature of the process is crucial;
* information should be shared fully with workers; and
* not all needs can be met.
a guide
to
additional resources

Section Six
SECTION SIX: A Guide to Additional Resources

1. Annotated Bibliography: Social and Health Related Research
2. References: Sources referred to in this Manual
1. Annotated Bibliography: Social and Health Related Research

Libraries of any tertiary institution are replete with books on research methods. This selection is of books and articles found especially insightful or useful by staff of SCHRU, with special attention to those dealing both with ‘the scientific process’ and with qualitative approaches to social research. Some works on public health, especially those which include discussion of actual research projects, are also included.

General Discussions and Research Methodology

Aboriginal Health Research Ethics Committee of South Australia
November 1989
Inaugural Bulletin
Adelaide: Aboriginal Health Organisation

A forum of combined Aboriginal health services in South Australia formed this committee due to concerns about previous research amongst Aboriginal communities. The organisations represented by this forum are: the Aboriginal Health Organisation, the Nganampa Health Council, the Yalata/Maralinga Health Service, the Pika Wiya Health Service, Woma Programs, the South Australia Trachoma and Eye Health Program, the Ceduna/Koonibba Health Service and the Aboriginal Medical Service.

This booklet (available through the Aboriginal Health Organisation in South Australia) outlines the role of this committee, namely, to monitor and co-ordinate medical and health research in Aboriginal communities of SA, to offer advice to communities on ethics, methodology, and potential benefits of research proposals, and to review research needs of Aboriginal communities in order to determine priorities for research. The booklet also provides guidelines for research, such as the importance of adherence to the National Health and Medical Research Council’s ethical guidelines, the acceptability of methodology to the Aboriginal communities concerned, and feedback to the community.

It is obligatory for anyone contemplating research which would involve Aboriginal communities to follow the advice of this booklet.
Anderson R., Davies J., Kickbusch I., McQueen D., & Turner J., (eds) 1988
*Health Behaviour Research and Health Promotion*

The Foreword reads: 'This book marks an important stage in the development of a fundamental programme of research and action'; that stage is the 'astonishing theoretical transformation which has occurred in little more than a decade', which has brought health and health promotion into the centre of a complex industrial, legal, economic, political and educational nexus. The call is, then, for intersectoral research, which should not be focussed only upon the poor and powerless, but upon the institutions and structures of power (which must also participate in health promotion).

Sections of this volume, which uses the 'new public health' perspective as its springboard, include: the development of concepts and research in health behaviour; approaches to the study of health behaviour; national surveys of health behaviour (all four chapters of which refer to methodological issues); research on health behaviour in local environments; the application of research in health behaviour; discussion papers on a new agenda for research in health behaviour.

Contributors span the northern hemisphere in their discussion of these matters. Not to be missed and well worth close attention.

Bailey K. D. 1978
*Methods of Social Research*

This comprehensive introductory textbook has valuable chapters on the research process, survey research method (including sampling), choosing the research problem (which includes segments on research paradigms with fleeting reference to Marxist interpretations), and value-free sociology. It concludes with chapters on ethics in social research, research applications (including discussion of some controversial social science studies, mostly American), constructing and revising complex theories, a handy glossary, and random number chart.

In between are chapters on constructing social explanations, questionnaire construction, interviewing, document studies, coding and data reduction, analysis and interpretation of data, and scaling—all cast in the familiar quantitatively-oriented paradigm. An interesting chapter on ethnomethodology and its relation to survey research, plus one on observation, go beyond the usual fare, and all
chapters on methods include some discussion on their advantages and disadvantages. The book has been billed as a 'practical guide to dealing with problems of social research that features a scholarly review of the literature, a clear view of the interrelationship of theory and research, and a carefully structured overview of approaches to research problems'. One is tempted to agree, with the important caveat that theoretical considerations are considered mostly from a positivist perspective; for example, the author seems to assume that replication in the social sciences can be exact, and results can be compared in a straight forward manner.

Bell C. & Encel S. 1978
*Inside the Whale: Ten Personal Accounts of Social Research*
Sydney: Pergamon Press

An interesting if rather dated book depicting the research experiences of ten professional social scientists working mostly in Australia. The problems discussed remain relevant, notably: the lack of action by government following recommendations based on the results of research; the discovery that much of the research turned out to be qualitative, even though it was quantitative in design and planning; and that the social research process is far from a straight-forward step-by-step application of rigid 'scientific method'.

Bradshaw J. 1972
*The Concept of Social Need*
*New Society* 30th March 1972, pp. 641-643

This article is one of the most frequently-quoted analyses of need. Bradshaw lists four different types of need based on how the need is identified. These are, normative needs - the needs of a community defined by experts who judge what a community needs on the basis of their experience; felt needs - what the members of a community say they want, for instance through a community survey; expressed needs - those needs that have been expressed by members of the community, for instance by putting their names on a waiting list; and comparative needs which arise when one community lacks services that are provided in another similar, community.

Bradshaw clarifies the relationship between needs and how they are assessed; however the clarification does not help determine priority for, as Bradshaw acknowledges, there is no reason to suppose that a need indentified by three sources has a higher priority than a need that has been indentified by only one source.
Community Development in Health Project Team 1988
*Community Development in Health - A Resources Collection*
Melbourne: Preston/Northcote District Health Council

A collection of resource materials for community health workers. Chapter One gives an historical account and theoretical perspective of the community development approach to health promotion. A good reference, giving the Australian experiences in community development in health.

Cornwell J. 1984
*Hard-Earned Lives*
London: Tavistock

*Hard-Earned Lives* is a consideration of the ‘common sense’ ideas and theories held on health, illness and health services by a group of families in the east end of London. Cornwell’s research is based on qualitative analysis and as such is a good example of the way detailed case data can be used to develop theories relating to health and illness.

She takes a look at individuals’ lives and sees how experiences and perceptions of health and illness differ. The book is based on detailed interviews with twenty-four individuals.

Easthope G. 1974
*A History of Social Research Methods*
London: Longman

This is mainly an historical account, but also discusses the two key features of all good social research: the recognition that all research methods are ultimately subjective; and the need for theoretical ideas to make sense of the data collected.

Fielding N. & Fielding J. 1988
*Linking Data: Qualitative Research Methods Series No. 4*
Beverley Hills, Cal: Sage Publications

Includes discussion on qualitative research designed to illuminate the grey zone between qualitative and quantitative research techniques in sociology, with a particular focus upon the analysis of data generated by various methods.

Sage is highly regarded both for its books on quantitative methods and for this series, but the authors wisely invite the reader not to concentrate purely on one to the detriment of the other. They are
complimentary series. The series editors comment that multiple approaches 'increase the possibility that the link between social reality and social theory is better forged'.

Sections in this book include ‘Comparative Methods in Social Science’, ‘Linking Qualitative Data’, and ‘Linking Qualitative and Quantitative Data’, with a conclusion on ‘The Value of Multi-method Work’. Despite being mostly a difficult read owing to the technical and theoretical level at which it is written, the authors’ longitudinal, multi-method study of police recruit training (which includes sections on Mapping Police Careers, Perspectives on Racial Attitudes, and the Limits of Instrumentalism) illustrates well the complexity of such a multi-method study and tells us much about how it was carried out, and how conclusions were reached. Qualitative data for this study included: a questionnaire completed by recruiting officers; recruits’ essays on why they wanted to join the police force; in-depth interviews with selected recruits, police instructors in the training school, field training officers, senior officers responsible for training, local lawyers, and politicians; plus observation of a sample of recruits, both in the training school and on the beat. Publications referred to in this book occasionally include health-related research topics, but the methodological and analytical lessons which can be learnt from the police study remain especially valuable and wide-ranging.

Fletcher C. 1974
Beneath The Surface: An Account of Three Styles of Sociological Research
London: Routledge & Kegan Paul

A very readable personal account by a sociologist who argues for the need to adopt a critical perspective in order to avoid the ‘laissez-faire anarchism’ that has often marred qualitative research. Chapter 5, entitled ‘Observations in a Surgery’ is a report of participant-observation fieldwork carried out in a British hospital.

Glazer M. 1972
The Research Adventure: Promise and Problems of Field Work
New York: Random House

A readable if over-enthusiastic account of experiences of academic sociologists and anthropologists in diverse fieldwork situations.
Grady K. & Wallston B. 1988
*Research in Health Care Settings*
Beverley Hills, Cal: Sage Publications

'Written for social scientists and health professionals who wish to do research ... reflecting the needs of large interdisciplinary research projects', says the summary. Stripped of mythology about the scientific research process, it reveals something of the 'nitty-gritty' of research. Chapters include: 'Health Care Settings and Collaborative Research', 'Asking Research Questions', 'Designing Studies', 'Selecting Samples', 'Choosing Measures and Using Existing Data', 'Self-Report and Other Report'. The book is peppered with examples of 'negotiations, confusion, serendipity, and ... patchwork solutions'. However, the authors articulate only a partial social health perspective; for example, health carers are generally assumed to be professionals, despite awareness that voluntarily-run community groups may be successfully involved in health care.

Some of the chapters address issues developed insufficiently in similar books, such as 'outsider' (gaining access) issues, and 'insider' (health worker role-conflict) issues, together with practical advice on creating research teams. Some pragmatic strategies include, for example: taking a dental hygienist to lunch to improve research response rates, and strategies for obtaining physician co-operation, with exercises at the end of each chapter. However, the book's overall orientation remains clinical and indeed positivist: for instance, the concept of measurement dominates even in the behavioural observation section. The use of existing scales is advocated, with the usual warnings about reliability and validity, yet scant attention is paid to the highly selective manner in which most scales have been developed (for example, 'college kid' sampling to establish 'normative data') and their subsequent limited utility in different socio-economic and cultural settings.

Nevertheless, the book remains useful and it adopts a refreshing and challenging 'Garbage Can' model of research, in which 'theories, methods, resources and solutions ... swirl about in the garbage can or decision-making space of a project'. This schema provides the canvas for a range of possible and complex outcomes: a far cry from the sterile, step-by-step rigidities of 'scientific' orthodoxy. Easy-to-read, non-technical style.
Hakim C. 1987
*Research Design: Strategies and Action in the Design of Social Research*
London: Allen & Unwin

A book for professional researchers, but patient readers will find useful insights into design and data collection. The chapter on 'case studies' method - the qualitative equivalent of the spotlight or the microscope - is highly recommended.

Halfpenny P. 1979
*The Analysis of Qualitative Data*
*Sociological Review* 27(4):799-825

Social science is a pluralistic discipline characterised by numerous alternative conceptions of the social world. This paper is a thorough and interesting discussion on the interpretation and handling of qualitative data in Structuralist, Interpretivist, Positivist and Ethnomethodological traditions of sociology. It is mainly for those already grounded in the social sciences or for those wanting to gain an overview of these varying perceptions of the nature of qualitative analysis.

Hawe P., Degeling D., & Hall J. 1990
*Evaluating Health Promotions: A Health Workers' Guide*
Sydney: MacLennan & Petty

This book provides a useful introduction to evaluation and program planning, and skills needed for evaluation. The second chapter is specifically on needs assessment and provides a useful introduction to the topic.

Kane, E. 1983
*Doing Your Own Research*
Dublin: Turoe Press

A useful book for people with little or no experience in social research. It does not deal with all qualitative methods, but has detailed discussions on how to carry out effective participant observation fieldwork and analysis.
Lofland J. 1971
*Analyzing Social Setting: A Guide to Qualitative Observation and Analysis*
Belmont, Cal: Wadsworth

A clearly written and definitive guide to anthropological research recommended. It emphasizes the need for checking the reliability of informants: what they say should never be taken as the final truth, a good reminder for any social science research.

Lupton G. & Najman J. (eds) 1989
*Sociology of Health and Illness: Australian Readings*
Melbourne: Macmillan

The book consists of a five-part structure, with an introductory discussion on a sociological perspective of Australian health, followed by sections on the structure and politics of health services in Australia; recipients of services (covering gender, inequality, ethnicity, and a socio-cultural perspective of Aboriginal health); providers of services (which examines medical training, nursing, work satisfaction and ‘alternative’ medicine); disease prevention and health promotion (including a discussion on the sociology of alcohol, drug, and tobacco use); and an overview. Most of the contributors are from the eastern States; nevertheless, this is essential reading for everyone involved in health care in Australia.

McCall G.J., & Simmons J.C., (eds) 1969
*Issues on Participant Observation*
Reading Mass: Addison-Wesley

Though dated, this is still regarded as one of the most comprehensive discussions on the issues, problems and solutions of participant observation fieldwork. The uninitiated may find Chapter 8 particularly useful; it deals with assessing the quality of data, the generation of hypotheses, and includes a section on comparison with quantitative methods.

National Aboriginal Health Strategy Working Party (NAHSWP) 1989
*A National Aboriginal Health Strategy.*
Canberra: Department of Aboriginal Affairs

This report is essential reading for anyone wanting not only a good overview of Aboriginal health in a statistical sense, but also an Aboriginal perspective on what is being and/or should be done in each of the States/Territories, and in each of the major health 'problem' areas or types. It includes a challenging and provocative
section on Aboriginal people’s concepts and perceptions of health in the Foreword entitled ‘Aboriginal Australia - The Reality and Not the Myth’, which should not be overlooked, as it also contains a section on Aboriginal community control and participation. The whole of Chapter 11 is devoted to Aboriginal health research, and a third of this report consists of a collection of submissions received by the working party from around Australia, giving background on the consultation process which brought this document into being, and on such diverse but intertwined issues as substance abuse amongst Aboriginal youth, the ethics of research into Aboriginal health, and funding arrangements for Aboriginal health services.

Many of these submissions contain insightful and practical discussions on public health matters, and primary health care generally in Australia. Aboriginal health workers have always advocated a social perspective of health. (The Commonwealth Bookshop should stock it, or local State libraries).

Patton M. 1987
How to Use Qualitative Methods in Evaluations
Beverley Hills, Cal: Sage Publications


The uncritical advocacy of ‘triangulation’ of methods as “ideal” (p. 61), is misleading, but there is plenty in this volume which remains practical and relevant to health researchers, both within and beyond the field of evaluation.

A helpful book for those looking at possible ways of mixing methodologies and analysis, from both quantitative and general approaches.
Pitt D. C. 1972
*Using Historical Sources in Anthropology and Sociology*
New York: Holt, Rinehart & Winston

A slim volume that argues for the virtue of using documentary sources to provide greater time depth and comparative insight in qualitative research. A useful guide to American bibliographical materials, but Australian readers will benefit from the author's critical evaluation of these resources.

Polgar S. & Thomas S. 1988
*Introduction to Research in the Health Sciences*
Melbourne: Churchill Livingstone

An introductory text, dealing with planning and design of clinical research, data collection, descriptive and inferential statistics, presentation, and critical evaluation of research. The material is practical, clearly presented and easy to understand. Self-test questions at the end of each chapter are useful, given its clinically-oriented limitations.

Richards L. 1990
*Nobody's Home: Dreams and Realities in a New Suburb*
Melbourne: Oxford University Press

A longitudinal community study of families in a new, outlying suburban area of Melbourne was carried out over a five year period. Presented as the result of a rigorous theoretical and empirical exploration of the dynamics of family-in-community, it is not a 'pop' sociology production but a scholarly and wide-ranging project, incorporating current sociological thought on the family and gender-related issues. Richards utilises both quantitative and qualitative data, and she illuminates their relation to each other with this comment (from the Introduction): 'For a study that acquired such vast quantities of survey data, this book relies very little on statistics. This is not from any lack of commitment to quantitative methods; indeed the study represents the belief that quantitative analysis is often essential. But it is qualitative data that drives the analysis'.

Furthermore, Richards adds: 'During the five year project there were several points at which the themes emerging as 'core categories' in the qualitative material at last made sense of puzzles in the survey data. I have attempted to tell how that happened rather than fudge the result as though I had always tidily hypothesised it'.
This book is well worthy of an extensive report. As Michael Traynor said in his review (Traynor 1990a): 'The researchers own up to confusion and mistaken notions and the researched exist as more than a series of disembodied mouths validating theories. You would almost recognise some of them if you met them in the street. The research refutes many time-honoured theories about women, isolation, private and public worlds and suburbia. Richards' argument, or rather her discovery, is that the picture is just much more complex than the old theories would have us believe. And one suspects that her beloved NUDIST (the computer software developed at La Trobe University during this research precisely for analysing qualitative data) has enabled her analysis to do justice to the richness of the data'. Richards also rejects the titles of 'researcher' for herself, and of 'respondent' for those amongst whom she worked.

'As Richards acknowledges, the "tangle of themes" that the research attempts to unravel make the book hard to summarise. It is essentially a study of ideas ... of what home ownership means, what family life is, what makes a good neighbour and a good neighbourhood. It shows how residents themselves mapped out the estate in terms of race, life stage, gender and fine variations of class despite claims by so many hard-pressed first-time owners that they were "all in the same boat". It also poses, and leaves hanging, a question about isolation which many at once endured yet desired. Privacy appeared to be a central component of the good family life. The neighbour that both men and women seemed to fear was not the one who failed to lend a hand, but the one who was "always in your pocket".' As planning healthy communities necessitates a close look at assumptions about family life in the community, and such fundamental issues as isolation and communication, research such as this, carried out over time in a local community setting, should prove a major resource for all who are involved in community health. Its results will not apply everywhere, but the author's sensitivity to the complexities of ideology, values, and others' research assumptions, together with the project's analytical openness, would seem to have major implications, not only for other research endeavours, but for health behaviour programs generally - especially those operating in suburban settings.

In summary, the book reveals the depth of the Richards' research into the dreams of home-ownership and into family life in its social setting (not its internal dynamics), and it 'should help to re-shape existing theories', as Traynor remarks. Available in paperback.
Rose G. 1982
*Deciphering Sociological Research*
London: Macmillan

This book begins with the assumption that a lot of social research involves reading and interpreting the research of others. Rose develops a deciphering technique by which a systematic analysis can be made of published research reports. His analytical schema is mainly designed for use with quantitatively oriented studies. Introductory chapters on the nature of the research process deal with such subjects as ‘Concepts and Indicators’, ‘Sampling’ and ‘Data Analysis’.

The book appears to be intended mainly for sociology students, but it has a wider application. It is ideal if you have ever read a published report and found it hard to grasp: a) how the evidence was related to theory; b) how the methodology was used to arrive at results; and c) what the results actually mean. And isn’t that all of us? Part One of the book develops and tests Rose’s deciphering technique, while Part Two consists of twelve research reports which are subjected to his analytic technique. These selected reports are edited versions of published articles with various topics in the fields of, for example, education and health. Two articles on health are featured: Multiple Drug Use among Marijuana Smokers, and The Burden of Rheumatoid Arthritis: Tolerating the Uncertainty. Rose’s deciphering schema may seem too rigid for some, but the reader who is serious about social research will find this book helpful, insightful and practical. Highly recommended.

Silverman D. 1985
*Qualitative Methodology & Sociology: Describing the Social World*
Aldershot, UK: Gower

The most thorough discussion of the theoretical and empirical aspects of the topic to date. Used extensively for the development of Section Four of this Manual because of the author’s depth of understanding and experience in sociological research into health and organisations. Not to be confused with a ‘methods cookbook’, and perhaps difficult reading for those not grounded in sociology. The reader is taken on a tri-sectioned discussion beginning with ‘The Research Process’ (beginning research, reviewing literature, specifying research problems, conducting the study, and looking at implications); ‘Overcoming Conceptual Polarities’; and ‘The Practice of Qualitative Research’ (including a chapter on conversation analysis, interview data, combining quantitative and qualitative methods, and concluding with ‘What can social science
contribute?"). For each section there is a brief recommended reading list.

Silverman is Reader in Sociology at the University of London. He has published extensively since the early 1970s, including articles on the child as social object (on Down's syndrome children). More recently, he is directing research attention (and exploring qualitative approaches in the process) to sexual behaviour in relation to health promotion and safe sex. Look out for those.

Tesch R. 1990
*Qualitative Research: Analysis Types and Software Tools*
London: Falmer Press

*Qualitative Research: Analysis Types and Software Tools* introduces two major types of analysis: structural and interpretational. The author distinguishes between conceptual and mechanical tasks for each and shows how the computer can assist the qualitative researcher during the analysis procedure. The book will be understood easily be anyone who can operate a word processor. It provides new material for the advanced computer user, although it should be noted that the Australian package NUDIST is not mentioned. The coverage of qualitative research approaches will be helpful to researchers wishing to broaden knowledge of qualitative research methods and to understand the various terms used in this field.

Contents include the following: 'Introduction', 'What this Book is About', 'How to Read this Book', 'History of Qualitative Research', 'Qualitative Research in Sociology', 'Qualitative Research in Psychology', 'Qualitative Research in Education', 'Types of Qualitative Research', 'Types of Qualitative Analysis', 'The Mechanics of Structural Qualitative Analysis', 'The Mechanics of Interpretational Qualitative Analysis', 'Organising Systems and How to Develop Them', 'Qualitative Analysis Programs (MS-DOS)', 'Basic Structures and Functions', 'How to Deal with a Computer', 'How to Read the Descriptions of Text Analysis Programs', 'Text Retrievers', 'Data Base Managers', 'ETHNO', 'Text Analysis Package (TAP)', 'QUALPRO', 'The Ethnograph', 'TEXTBASE ALPHA', 'HyperQual', 'Conclusion and Outlook'.

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Wadsworth Y. 1984
Do-It-Yourself Social Research
Melbourne: Victorian Council of Social Services and Melbourne Family Care Organisation

Health workers should read this before embarking on a research project. The book is devoid of jargon and contains important sociological messages: the need to recognize power relations in the health system, and the importance of sociological ideas that inform all research planning and analysis. Read carefully Chapter 2 'Before you Start', especially the section: What is knowledge and how do we know?

Walker R. (ed) 1985
Applied Qualitative Research
Aldershot, UK: Gower

A book about methodological problems written by research consultants. Chapter 5 contains a complete discussion of the advantages and limitations of the Focus Group method, which highlights the social interactions between researcher and respondents and among respondents themselves.

Beginning with Statistics and Numerical Data Analysis

Hartwig F. & Dearing B. 1979
Exploratory Data Analysis

Irvine J., Mills I. & Evans J. (eds) 1979
Demystifying Social Statistics
London: Pluto Press (390 pp.)

Marsh C. 1988
Exploring Data: an Introduction to Data Analysis for Social Scientists
Cambridge: Polity Press (385 pp.)

Wonnacott T. H. & Wonnacott R. J. 1977
Introductory Statistics (3rd Edition)
New York: Wiley (650 pp.)
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ABS (Australian Bureau of Statistics) 1989 *An Introduction to Sample Surveys*. Cat. No. 1202.2

ACHA (Australian Community Health Association) 1986 *Review of the Community Health Program*. Sydney: ACHA


ACOSS (Australian Council of Social Service) 1973 *Poverty: The ACOSS Evidence*. Sydney: ACOSS


AHMAC (Australian Health Ministers Advisory Council) 1988 *Continuing Education for Primary Health Care in Australia: Report and Recommendations*. [Canberra]: AHMAC


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NHHSC (National Hospitals & Health Services Commission: Interim Committee) 1973 A Community Health Program for Australia. Canberra: AGPS
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Power V. 1987 AEF correspondence to the National Health and Medical Research Council, December 1987


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SCHRU (Southern Community Health Research Unit) 1986
Noarlunga's Health - Apathy or Action? Adelaide: SCHRU

SCHRU (Southern Community Health Research Unit) 1987

Segall M. H. 1979 quoted in Reser J. 1990 Perspective on the Causes and Cultural Context of Violence in Aboriginal Communities in Northern Queensland: A Report to the Royal Commission into Aboriginal Deaths in Custody. Townsville: School of Behavioural Sciences, James Cook University of North Queensland


Silverman D. 1985 Qualitative Methodology in Sociology. Aldershot, UK: Glower


SSCSW (Senate Standing Committee on Social Welfare) 1979

Strauss A. 1987 Qualitative Analysis for Social Scientists. Cambridge: Cambridge University Press


WHO (World Health Organization) 1986 The Ottawa Charter for Health Promotion. Health Promotion 1(4):iii-v
appendices

Section Seven
SECTION SEVEN : Appendices

1.1 Information Useful for Planning Healthy Communities
1.2 Map (Single Parent Families, Adelaide)
1.3 Map (Department of Community Welfare Clients, Adelaide)
1.4 Questionnaires for Marion, Brighton and Glenelg (MARBRIG) Community Health Needs Assessment
1.5 Community Consultation Guidelines for MARBRIG Community Health Needs Assessment
3.1 Table of Random Numbers and Explanation
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3.3 Cover of MARBRIG Questionnaire
3.4 First and Second Reminder Cards - MARBRIG Community Health Needs Assessment
3.5 First Reminder Letter - Lower North Community Health Needs Assessment
3.6 Second Reminder Letter - MARBRIG Community Health Needs Assessment
3.7 Questionnaires for Special Groups
5.1 Cartoons in MARBRIG Report
5.2 Press Release for MARBRIG ‘Youth Report’
5.3 Invitation to Health Issues Day, Noarlunga
# Checklist of information likely to be useful for Planning Healthy Communities

<table>
<thead>
<tr>
<th>Topics</th>
<th>Type of Information</th>
<th>Data Source/Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PERCEPTIONS OF AREA</strong></td>
<td>Residents’ views about desirability, safety, nature of area. Attitudes and beliefs concerning health &amp; illness and available services. Perceptions of key health problems.</td>
<td>Population surveys, participant observation, focus groups, interviews, document analysis including media (eg, newspapers, especially letters to the editor in locally circulated press).</td>
</tr>
<tr>
<td><strong>SUPPORT NETWORKS</strong></td>
<td>Contact between residents, informal caring, methods of information dispersal, social interaction, community ‘hubs’ (or lack) of: what is the impetus or driving force of this interaction?</td>
<td>Mainly participant observation, some in-depth interviews, limited use for surveys.</td>
</tr>
<tr>
<td><strong>COMMUNITY NORMS, VALUES &amp; TRADITIONS</strong></td>
<td>A feel for local beliefs and variations in these. Awareness of local ethnic groups: their attitudes, values, concerns. Presence or absence of significant museums, festivals, traditional rituals. Religious expressions and involvement in health-related concerns. Gender relations: their expression in domestic and wider social life. Print and electronic media: state and local.</td>
<td>Mainly participant observation, some in-depth interviews, Local history documents.</td>
</tr>
<tr>
<td><strong>Locality and Infrastructure</strong></td>
<td><strong>HOUSING &amp; PLANNING</strong>&lt;br&gt;Overview of type &amp; suitability of housing. Adequacy of planning and provision of services. Housing needs of different groups (e.g. young people, and those with disabilities). Private and public ownership; rental market.</td>
<td>Department of Environment &amp; Planning. Housing Trust/Commission. Plus qualitative methods for perceptions. Local government, housing surveys, ABS, Public housing bodies/ libraries. Resident’s associations/action groups, co-operatives.</td>
</tr>
<tr>
<td><strong>WATER, SEWERAGE, ENERGY SOURCES</strong></td>
<td>Availability and type of supply?</td>
<td>State government information services.</td>
</tr>
</tbody>
</table>
### Appendix 1.1 (Cont.)

<table>
<thead>
<tr>
<th>Topics</th>
<th>Type of Information</th>
<th>Data Source/ Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisations &amp; Services</strong></td>
<td>Inventory of local services (with focus on health &amp; welfare), and professional and non-professional perceptions of gaps. Extent of cooperation or conflict between agencies.</td>
<td>From information services and steering committee.</td>
</tr>
<tr>
<td><strong>STATE &amp; LOCAL GOVT.</strong></td>
<td>Inventory of these, including self-help groups, &amp; lobbying groups.</td>
<td>Local Government, community information services, associations, steering committee.</td>
</tr>
<tr>
<td><strong>NON-GOVERNMENT &amp; COMMUNITY GROUPS</strong></td>
<td>Social planning committees, community forums</td>
<td>As above</td>
</tr>
<tr>
<td><strong>BUSINESS &amp; ECONOMIC</strong></td>
<td>Analysis of administrative structure and politics (fed, state and local government : lobby groups). Perceptions of power holders and others. Analysis of extent of communication between different sectors and levels of government. Assessment of ability of the community to influence decision making. Where is power centred? Balance/imbalance of health-related expenditure. Clinical/medical health vs. social/community health.</td>
<td>Formal documents, council minutes, Parliament records (e.g. Hansard), In-depth interviews; analysis of business and organisations as above, Labour market, housing market, class and status considerations.</td>
</tr>
<tr>
<td><strong>ADMINISTRATION &amp; POWER</strong></td>
<td>Description of location, rainfall, temperature ranges, topography, etc. Air and water quality/pollution.</td>
<td>Year book, meteorological office, departments that deal with the natural environment, and monitor air and water quality, and soil pollution.</td>
</tr>
<tr>
<td><strong>Natural Environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLIMATE, GEOGRAPHY,</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ENVIRONMENTAL HEALTH</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 1.2

Map (single parent families, Adelaide)

Map 2.7
Single parent families, Metropolitan Adelaide, 1986
as a percentage of all families in each postcode

6.0 per cent of families in Metropolitan Adelaide were single parent families at 30 June 1986.

Per cent single parent families:
- 12.0% or more
- 10.0% to less than 12.0%
- 8.0% to less than 10.0%
- 6.0% to less than 8.0%
- less than 6.0%
- data unreliable

Note: Overlaid boundaries are local government areas.
Source: Calculated on data from ABS 1986 Census

Social Health Atlas Project, South Australian Health Commission, 1989
APPENDIX 1.3

Map (Department of Community Welfare clients, Adelaide)

Map 4.14
Department for Community Welfare client intake, females, Metropolitan Adelaide, 1987-88
actual intake\(^1\) (by postcode)
compared with the number expected\(^1\) (based on SA totals)

Total DCW intake\(^4\) of female clients resident in Metropolitan Adelaide was 23.5 per cent lower than expected\(^2\) (based on SA totals)

Actual intake\(^1\) compared with the number expected\(^1\)

- 60.0% or more higher
- 30.0% to 59.9% higher
- 29.9% lower to 20% higher
- 30.0% to 59.9% lower
- 60.0% or more lower
- less than 5 clients
- data unreliable

\(^4\)Includes intake of individuals only, excludes intake of families and groups
\(^1\)Expected intake was derived by indirect age standardisation, based on SA totals
\(^2\)Note: Overlaid boundaries are local government areas

Source: Standardised on data from DCW

Social Health Atlas Project, South Australian Health Commission, 1989
APPENDIX 1.4

Questionnaires for Marion, Brighton and Glenelg (MARBRIG) Community Health Needs Assessment
Please Read The Following Instructions Before Answering The Questions:

1) We have made the questionnaire as short as possible. Each question has been selected specifically to measure the need for health and community services in your area.

2) It should take approximately 20 minutes to complete.

3) Please complete ALL the questions.

4) YOUR ANSWERS WILL REMAIN STRICTLY CONFIDENTIAL.

5) If you have any problems completing the questionnaire please phone the Research Unit (326 0433) and we will either help you over the phone or arrange for someone to come and assist you.

6) Please try to complete the questionnaire as soon as possible as this will save us sending you reminder letters.

7) When you have completed the questionnaire, please return it in the envelope provided.

THANK YOU FOR YOUR CO-OPERATION
WE HOPE THAT YOU ENJOY COMPLETING THIS QUESTIONNAIRE
SECTION 1: HEALTH AND ILLNESS

1. Were you sick, injured or feeling unwell at all in the last two weeks?

   YES [ ]

   NO [ ] ➔ GO TO Q. 3

IF YES,
What was the cause of this?

(Please tick one or more answers)

COLD, FLU, SORE THROAT OR VIRAL INFECTION.............[ ]
STOMACH OR BOWEL PROBLEMS.................................[ ]
ACCIDENTAL INJURY................................................[ ]
BACK-STRAIN OR PAIN.............................................[ ]
HEADACHE.............................................................[ ]
DEPRESSION..........................................................[ ]
OTHER (please state)..............................................

............................................................................

...NOW THAT YOU COME TO MENTION IT...
2. 
(a) Did you seek help or attention for this condition?  
(If more than one, select the most serious).  
(Please tick YES or NO)

YES [   ]  ⇒ Go to Q. 2b

NO [   ]  ⇒ Go to Q. 2c

(b) If YES, Where did you seek help or attention?  
(Please tick one or more answers)

DOCTOR’S SURGERY ........................................ [   ]
CASUALTY DEPARTMENT OF HOSPITAL ................... [   ]
WORK CLINIC ................................................. [   ]
COLLEGE OR UNIVERSITY CLINIC ....................... [   ]
CHEMIST ........................................................ [   ]
FRIEND .......................................................... [   ]
WORKMATE ....................................................... [   ]
OTHER (please state) .........................................

..............................................................

PLEASE GO TO Q. 3

(c) If NO, what was the main reason you didn’t seek help or attention?  
(Please tick one answer)

NOT SERIOUS ENOUGH ........................................ [   ]
DON’T LIKE GOING TO THE DOCTOR .................... [   ]
NOT ENOUGH TIME ...........................................[   ]
TRANSPORT DIFFICULTIES GETTING TO HEALTH SERVICES .......... [   ]
DIDN’T KNOW WHERE TO GO ................................ [   ]
OTHER (please state reason) ................................

..............................................................
3. How often have you experienced the following health problems in the last twelve months? Please tick under **OFTEN** or **SOMETIMES** or **NOT AT ALL**.

<table>
<thead>
<tr>
<th>Condition</th>
<th>OFTEN</th>
<th>SOMETIMES</th>
<th>NOT AT ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritic Pain</td>
<td>[</td>
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<tr>
<td>Rheumatic Pain</td>
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<td>Indigestion</td>
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<td>Back Trouble</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Feeling Stressed</td>
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<tr>
<td>Cold or Flu</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Other Breathing Problems (e.g. Emphysema)</td>
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<td>[</td>
</tr>
<tr>
<td>Migraine or Headache</td>
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<tr>
<td>Feeling Irritable</td>
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<tr>
<td>Allergies (e.g. Hay Fever etc.)</td>
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<tr>
<td>Worry about Your Weight</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Stomach Pains/Bowel Pains</td>
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<tr>
<td>Problems with Diabetes</td>
<td>[</td>
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<tr>
<td>Repetition Strain Injury (RSI)</td>
<td>[</td>
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<tr>
<td>Menstrual Problems (for women)</td>
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</tbody>
</table>
4. In general, what has your health been like in the last 12 months?  
(Please tick the answer which is most true for you)

VERY GOOD....................[ ]
GOOD.........................[ ]
FAIR..........................[ ]
POOR..........................[ ]
VERY POOR....................[ ]

5. Listed below are some problems people may experience in their daily life. Please tick YES for any problems that you have at the moment, and tick NO for any problems you do not have.

PLEASE ANSWER EVERY QUESTION. If you are not sure whether to say YES or NO, tick whichever answer you think is more true at the moment.

YES          NO

I'M TIRED ALL THE TIME.........................[ ] [ ]
I HAVE PAIN AT NIGHT.........................[ ] [ ]
THINGS ARE GETTING ME DOWN..................[ ] [ ]

YES          NO

I HAVE UNBEARABLE PAIN.........................[ ] [ ]
I TAKE TABLETS TO HELP ME SLEEP.............[ ] [ ]
I'VE FORGOTTEN WHAT IT'S LIKE TO ENJOY MYSELF.................................[ ] [ ]

YES          NO

I'M FEELING ON EDGE...........................[ ] [ ]
I FIND IT PAINFUL TO CHANGE POSITION.......[ ] [ ]
I FEEL LONELY.................................[ ] [ ]
YES  NO
I CAN ONLY WALK ABOUT INDOORS........................[  ] [  ]
I FIND IT HARD TO BEND................................[  ] [  ]
EVERYTHING IS AN EFFORT...............................[  ] [  ]

YES  NO
I'M WAKING UP IN THE EARLY HOURS OF
THE MORNING.............................................[  ] [  ]
I'M UNABLE TO WALK AT ALL.............................[  ] [  ]
I'M FINDING IT HARD TO MAKE CONTACT
WITH PEOPLE............................................[  ] [  ]

YES  NO
THE DAYS SEEM TO DRAG..................................[  ] [  ]
I HAVE TROUBLE GETTING UP AND DOWN
STAIRS OR STEPS......................................[  ] [  ]
I FIND IT HARD TO REACH FOR THINGS...............[  ] [  ]

YES  NO
I'M IN PAIN WHEN I WALK................................[  ] [  ]
I LOSE MY TEMPER EASILY THESE DAYS...............[  ] [  ]
I FEEL THERE IS NOBODY I AM CLOSE TO...............[  ] [  ]

YES  NO
I LIE AWAKE FOR MOST OF THE NIGHT..................[  ] [  ]
I FEEL AS IF I'M LOSING CONTROL.....................[  ] [  ]
I'M IN PAIN WHEN I'M STANDING.......................[  ] [  ]

REMEMBER IF YOU ARE NOT SURE WHETHER TO ANSWER
YES OR NO TO A PROBLEM, TICK WHICHEVER ANSWER
YOU THINK IS MORE TRUE AT THE MOMENT.
YES NO
I FIND IT HARD TO DRESS MYSELF...........................[ ] [ ]
I SOON RUN OUT OF ENERGY..............................[ ] [ ]
I FIND IT HARD TO STAND FOR LONG (e.g. at
the kitchen sink, waiting for the bus)........[ ] [ ]

YES NO
I'M IN CONSTANT PAIN......................................[ ] [ ]
IT TAKES ME A LONG TIME TO GET TO SLEEP........[ ] [ ]
I FEEL I AM A BURDEN TO PEOPLE......................[ ] [ ]

YES NO
WORRY IS KEEPING ME AWAKE AT NIGHT...............[ ] [ ]
I FEEL THAT LIFE IS NOT WORTH LIVING...............[ ] [ ]
I SLEEP BADLY AT NIGHT.................................[ ] [ ]

YES NO
I'M FINDING IT HARD TO GET ON WITH PEOPLE.......[ ] [ ]
I NEED HELP TO WALK ABOUT OUTSIDE (e.g. a
walking aid or someone to support me).........[ ] [ ]
I'M IN PAIN WHEN GOING UP AND DOWN STAIRS
OR STEPS..............................................[ ] [ ]

YES NO
I WAKE UP FEELING DEPRESSED..........................[ ] [ ]
I'M IN PAIN WHEN I'M SITTING...........................[ ] [ ]
Listed below are some activities which may be affected by your state of health. Please tick **YES** for each activity that is being affected by your state of health. Tick **NO** for each activity which is not being affected, or does not apply.

Is your present state of health causing problems with your?

<table>
<thead>
<tr>
<th>Activity</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAID EMPLOYMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOOKING AFTER THE HOME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Examples: cleaning and cooking, repairs, odd jobs around the home, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIAL LIFE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Examples: going out, seeing friends, going to the pub, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOME LIFE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(That is: relationships with other people in your home)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEX LIFE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INTERESTS AND HOBBIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Examples: sports, arts and crafts, &quot;Do-It-Yourself&quot; projects, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOLIDAYS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. How important are the following dietary activities for your health?

Example: If you are not sure circle (1), if you think the activity is not important circle (2), if you think it is quite important circle (3), if you think it is very important circle (4).

<table>
<thead>
<tr>
<th>Activity</th>
<th>NOT SURE</th>
<th>NOT IMPORTANT</th>
<th>QUITE IMPORTANT</th>
<th>VERY IMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not adding sugar to your tea or coffee</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Avoiding soft or fizzy drinks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Trimming the fat from meat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Grilling meat rather than frying</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Substituting white meat (poultry) for red meat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Substituting poly-unsaturated margarine for butter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Not adding salt to your food at the table</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Eating more wholegrain rather than white bread</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Adding bran to a meal every day</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Avoiding foods with additives and colouring agents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Eating more organically grown food</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Eating fruit and vegetables every day</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Which of the following best describes your usual way of eating?

VEGETARIAN ............................... [ ]
WEIGHT REDUCTION DIET .................... [ ]
DIABETIC DIET ............................. [ ]
FAT MODIFIED DIET TO LOWER BLOOD FAT ............................. [ ]
SALT MODIFIED DIET TO LOWER BLOOD PRESSURE .................... [ ]
NO SPECIAL DIET ..................................... [ ]
OTHER .................................................. [ ]

9. (a) How often, on average, do you drink alcohol?

DAILY ................................................. [ ]
SEVERAL TIMES A WEEK ..................... [ ]
ONCE OR TWICE A WEEK .................... [ ]
LESS THAN ONCE A WEEK .................... [ ]
NEVER .................................................. [ ]

(b) If you drink alcohol, what types do you usually drink?

(Please tick one or more answers)

BEER (normal strength) ..................... [ ]
BEER (low alcohol) ........................... [ ]
CIDER .................................................. [ ]
WINE .................................................. [ ]
SPIRITS ............................................... [ ]
FORTIFIED WINE (PORT, SHERRY, etc.) ......................... [ ]
OTHER (please state) .......................... [ ]

10 (a) Have you ever smoked regularly?

YES [ ] \rightarrow GO TO Q. 10b
NO [ ] \rightarrow GO TO Q. 11

(b) (IF YES) Do you currently smoke?

YES [ ] \rightarrow GO TO Q. 10c
NO [ ] \rightarrow GO TO Q. 11

(c) (IF YES) How many cigarettes, on average, do you smoke each day?

............... cigarettes
11. How often do you have a blood pressure check?

- More than once a year
- Once a year
- Every two years
- Every three or four years
- Every five years or less often
- Never had one
- Only when pregnant or ill
- Not sure

12. How often do you have a blood test for your cholesterol level?

- More than once a year
- Once a year
- Every two years
- Every three or four years
- Every five years or less often
- Never had one
- Not sure

13. How often do you go to the dentist for treatment or check-up?

- More than once a year
- Once a year
- Every two years
- Every three or four years
- Every five years or less often
- Never been

14. How many times a week do you engage in sport or exercise which does not make you sweat or feel out of breath, including gardening or walking?

- Not at all
- Once or twice a week
- Three or more times a week

15. How many times a week do you play sport or exercise, for a period of at least 20 minutes, which makes you sweat or feel out of breath?

- Not at all
- Once or twice a week
- Three or more times a week
FOR WOMEN ONLY

16. How often do you examine or feel your breasts to check for lumps?

AT LEAST ONCE A MONTH ........................................... [ ]
SEVERAL TIMES A YEAR ........................................... [ ]
ONCE A YEAR ......................................................... [ ]
LESS THAN ONCE A YEAR ......................................... [ ]
NEVER .................................................................... [ ]
I NEVER DO IT MYSELF e.g. DOCTOR DOES IT ............... [ ]
NOT APPLICABLE ...................................................... [ ]

FOR WOMEN ONLY

17. How often do you have a Pap smear test for cancer?

MORE THAN ONCE A YEAR ........................................... [ ]
ONCE A YEAR .......................................................... [ ]
EVERY 2 YEARS ....................................................... [ ]
EVERY 3 YEARS ........................................................ [ ]
EVERY 4 OR 5 YEARS ................................................ [ ]
EVERY 6 YEARS OR LESS OFTEN ................................. [ ]
NEVER .................................................................... [ ]
NOT SURE WHAT A PAP SMEAR IS .............................. [ ]
SECTION 2: ABOUT YOU

18. Are you? MALE [ ] FEMALE [ ]

19. How old are you?

17-19 [ ] 50-54 [ ]
20-24 [ ] 55-59 [ ]
25-29 [ ] 60-64 [ ]
30-34 [ ] 65-69 [ ]
35-39 [ ] 70-74 [ ]
40-44 [ ] 75-79 [ ]
45-49 [ ] 80+ [ ]

20. What is your marital status?
(Please tick one answer)

SINGLE ..............................................................[ ]
MARRIED ............................................................[ ]
LIVING IN A DE FACTO RELATIONSHIP ....................[ ]
SEPARATED ..........................................................[ ]
DIVORCED ...........................................................[ ]
WIDOWED ...........................................................[ ]
OTHER (please state) ...........................................[ ]

21. Where were you born?

AUSTRALIA .........................................................[ ]
NEW ZEALAND .....................................................[ ]
UNITED KINGDOM ................................................[ ]
EUROPE ............................................................[ ]
ASIA .................................................................[ ]
NORTH AMERICA ................................................[ ]
OTHER (please state) ...........................................[ ]

22. What language is spoken most often in the house where you live?

ENGLISH .............................................................[ ]
VIETNAMESE .......................................................[ ]
ITALIAN ............................................................[ ]
GREEK ..............................................................[ ]
OTHER (please state) ...........................................[ ]
23. Which of the following best describes what you have been doing in the past 2 weeks?  
(Please tick one answer)

FULL TIME WORK IN A JOB, TRADE, BUSINESS OR PROFESSION

PART TIME WORK IN A JOB, TRADE, BUSINESS OR PROFESSION

CARING FOR HOME FULL TIME AND NOT LOOKING FOR WORK

STUDENT

PERMANENTLY UNABLE TO WORK

RETIRED

UNEMPLOYED - LOOKING FOR WORK

OTHER (Please state which) ...........................................

GO TO Q. 24

GO TO Q. 26

GO TO Q. 25

24. If working full or part-time, what is your job?

(Please describe as fully as possible, e.g. not just "clerk", but "clerk, Class 1 in the Department of Environment", not just "mechanic", but "motor mechanic at garage").

...........................................................................

...........................................................................

...........................................................................

PLEASE GO TO Q. 26
25. If unemployed and currently looking for work -

How long have you been unemployed and looking for work?

3 MONTHS OR LESS ......................................................... [ ]
OVER 3 MONTHS – 6 MONTHS ......................................... [ ]
OVER 6 MONTHS – 12 MONTHS ......................................... [ ]
OVER 1 YEAR – 2 YEARS .................................................. [ ]
OVER 2 YEARS – 3 YEARS ................................................ [ ]
OVER 3 YEARS – 5 YEARS ................................................ [ ]
OVER 5 YEARS ............................................................... [ ]

26. What is your highest level of education?

NO FORMAL SCHOOLING .................................................. [ ]
PRIMARY SCHOOL .......................................................... [ ]
SECONDARY SCHOOL (HIGH, TECH, ETC.) ......................... [ ]
TRADE OR BUSINESS QUALIFICATION ............................ [ ]
DEGREE OR TERTIARY DIPLOMA .................................... [ ]
HIGHER DEGREE ............................................................ [ ]

[Hand-drawn illustration: "How's your stamina?"
"...I'm up to question 26!"}
27. What was your total household income before tax last financial year? (If unsure, please estimate) (Please include the income of everyone in your family who is living with you)

LESS THAN $4,000.................................................[ ]
$4,001 - $9,000................................................[ ]
$9,001 - $15,000................................................[ ]
$15,001 - $22,000...............................................[ ]
$22,001 - $26,000..............................................[ ]
$26,001 - $32,000..............................................[ ]
$32,001 - $40,000..............................................[ ]
$40,001 - $50,000..............................................[ ]
$50,001 - $60,000..............................................[ ]
$60,001 - $70,000..............................................[ ]
$70,001 - $80,000..............................................[ ]
OVER $80,000....................................................[ ]

28. Which of the following is your household's main source of income? (Please tick one answer only)

SALARY AND WAGES.................................................[ ]
UNEMPLOYMENT BENEFITS........................................[ ]
SOCIAL SECURITY PENSION......................................[ ]
SELF-EMPLOYED..................................................[ ]
AUSTUDY.............................................................[ ]
SUPPORTING PARENT BENEFIT...................................[ ]
SICKNESS BENEFIT................................................[ ]
INCOME FROM BUSINESS OR PROPERTY......................[ ]
INSURANCE, INTEREST, DIVIDENDS, OR SUPERANNUATION. [ ]
OTHER (please state)............................................[ ]
29. How long have you lived in the area or neighbourhood you live in now?

LESS THAN 6 MONTHS.................................................[ ]
6 - 11 MONTHS.........................................................[ ]
1 YR - 5 YEARS.........................................................[ ]
6 YEARS - 10 YEARS....................................................[ ]
MORE THAN 10 YEARS...................................................[ ]

30. In the house or flat where you are now living, are you?

THE OUTRIGHT OWNER/JOINT OUTRIGHT OWNER.....................[ ]
PAYING OFF A MORTGAGE...............................................[ ]
RENTING FROM THE HOUSING TRUST..................................[ ]
RENTING PRIVATELY.......................................................[ ]
BOARDING.......................................................................[ ]
BOARDING WITH RELATIVES.............................................[ ]
IN HOSTEL ACCOMMODATION OR NURSING HOME..................[ ]
OTHER (please state).......................................................[ ]
....................................................................................

31. Including yourself, how many people usually live in your home?

NUMBER OF ADULTS

NUMBER OF CHILDREN
32. Do you have a connected telephone in your home?
   YES.................................................[ ]
   NO..............................................[ ]

33. Do you have a current driver's licence?
   YES.................................................[ ]
   NO..............................................[ ]

34. Do you normally have a car available for use on week days? (i.e. Monday to Friday)
   ALWAYS.........................................[ ]
   SOMETIMES.......................................[ ]
   NEVER.........................................[ ]

35. Do you normally have a car available for use at the weekends? (i.e. Saturday and Sunday)
   ALWAYS.........................................[ ]
   SOMETIMES.......................................[ ]
   NEVER.........................................[ ]

36. Do you use public transport (trains, buses, trams)?
   EVERY DAY.....................................[ ]
   ONCE OR TWICE A WEEK.......................[ ]
   OCCASIONALLY..................................[ ]
   NEVER.........................................[ ] - If never, why not?
   ........................................................................
   ........................................................................
37. Would you use public transport more if -

(Please tick the most appropriate answer in each line)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE BUS/TRAIN/TRAM RAN MORE FREQUENTLY</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>THE BUS/TRAIN/TRAM RAN ON TIME</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>THE BUS/TRAIN/TRAM STOP WAS CLOSER TO YOUR HOME</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>THERE WAS SOMEONE TO HELP YOU GET ON THE BUS/TRAIN/TRAM</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>FARES WERE CHEAPER</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>CONNECTIONS WERE BETTER</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
| OTHER (please state) | ........................................ | ....... | ...

38. Do you currently have private Health Insurance cover?

| YES | [ ] |
| NO | [ ] |
39. How often do you talk (either face-to-face or on the phone) with the following people? (Please tick the most appropriate answer in each line).

<table>
<thead>
<tr>
<th></th>
<th>Daily</th>
<th>Once</th>
<th>Several</th>
<th>Several</th>
<th>About</th>
<th>Rarely</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents-In-Law...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers or Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Adult Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Relatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Friends...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Neighbours...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

40. If you had a serious personal crisis, how many people do you feel you could turn to for help and comfort?

- None
- One
- Two
- Three
- More than three
SECTION 3: COMMUNITY CARE

41. (a) Apart from any paid work, do you care for, or help to care for, any person who is aged or has a disability?

YES [ ] → PLEASE CONTINUE WITH THE FOLLOWING QUESTIONS

NO [ ] → PLEASE GO TO NEXT SECTION, PAGE 23

(b) Is the person you care for?
(Please tick one or more answers)

PHYSICALLY DISABLED............................[ ]
INTELLECTUALLY DISABLED
OR BRAIN DAMAGED............................[ ]
MENTALLY ILL...................................[ ]
ELDERLY..........................................[ ]
CHRONICALLY ILL...............................[ ]
OTHER (please state)............................
................................................................
................................................................

(c) Do you live in the same house as the person you care for?
YES [ ]
NO [ ]

(d) Approximately how many days per week do you care for this person? ............days

Approximately how many hours per week? ............hours
(e) Is caring for this person causing you?  
(Please tick YES or NO for each answer)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO RESTRICT YOUR ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL HARDSHIP</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL ILLNESS</td>
<td></td>
</tr>
<tr>
<td>STRESS</td>
<td></td>
</tr>
<tr>
<td>A GOOD DEAL OF SATISFACTION</td>
<td></td>
</tr>
<tr>
<td>OTHER (please state)</td>
<td></td>
</tr>
</tbody>
</table>

(f) Who at present is helping you care for this person?  
(Please tick one or more answers)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO-ONE</td>
<td></td>
</tr>
<tr>
<td>FRIEND(S)</td>
<td></td>
</tr>
<tr>
<td>RELATIVE(S)</td>
<td></td>
</tr>
<tr>
<td>DEPARTMENT OF COMMUNITY WELFARE</td>
<td></td>
</tr>
<tr>
<td>COUNCIL SOCIAL WORKER</td>
<td></td>
</tr>
<tr>
<td>DOMICILIARY CARE</td>
<td></td>
</tr>
<tr>
<td>DOCTOR</td>
<td></td>
</tr>
<tr>
<td>DISTRICT NURSE</td>
<td></td>
</tr>
<tr>
<td>OTHER (please state)</td>
<td></td>
</tr>
</tbody>
</table>
(g) Do you need more help to care for this person?

YES [ ]

NO [ ] ➔ GO TO NEXT SECTION

QUESTION 42

If yes, what kind of help? (Please state)

........................................................................................................
........................................................................................................
........................................................................................................
SECTION 4. HEALTH AND COMMUNITY SERVICES

42. Please look at the following list and tick USED if you used the service in the last 12 months, and tick NOT USED if you have not used the service in the last 12 months.

<table>
<thead>
<tr>
<th>Service</th>
<th>USED</th>
<th>NOT USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital - Outpatient</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hospital - Inpatient</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Doctor - G.P.</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chemist</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Legal Aid</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Department for Community Welfare</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Department of Social Security</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Housing Trust (S.A.H.T.)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Community Health Centre</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Work-Based Medical Service</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Work-Based Health Education Service</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other Counselling Service</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (Please state which)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

"What a long list!

...Didn't know there were so many things we could use!"
43. Please look at the following list of professionals and tick **USED** if you consulted the person in the last 12 months, and tick **NOT USED** if you have not consulted the person in the last 12 months.

<table>
<thead>
<tr>
<th>Professional</th>
<th>USED</th>
<th>NOT USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR - G.P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOCTOR - SPECIALIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSE WHO CAME TO YOUR HOUSE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSE AT A CLINIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIROPRACTOR/OSTEOPATH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NATUROPATH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOMEOPATH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HERBALIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACUPUNCTURIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MASSEUR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIETICIAN OR NUTRITIONIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHIATRIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHOLOGIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPTICIAN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PODIATRIST/CHIROPODIST (FOOT SPECIALIST)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DENTIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIAL WORKER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPEECH PATHOLOGIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEALTH EDUCATOR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCCUPATIONAL THERAPIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSIOTHERAPIST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER (Please state which)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
44. Please rate your level of satisfaction with the following services and facilities that are available in your community. (If you are satisfied with the service circle (1), if neither satisfied nor unsatisfied circle (2), if dissatisfied circle (3), if the service is not applicable to you circle (4).

<table>
<thead>
<tr>
<th>Service</th>
<th>Satisfied</th>
<th>Neither Satisfied</th>
<th>Dissatisfied</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFORMATION SERVICE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>PLACES TO MEET OTHER PEOPLE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>SPORTING AND RECREATION FACILITIES</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>PUBLIC TRANSPORT</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>JOB-FINDING SERVICES</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>PARKS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>SHOPS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CINEMA AND THEATRE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CHILDREN'S PLAYGROUND(S)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>FULL-TIME CHILDCARE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>OCCASIONAL CHILDCARE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>HOSPITALS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>COFFEE SHOPS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>PUBS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>COMMUNITY HEALTH CENTRE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>HOME OR NURSING HELP</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

(QUESTION CONTINUES ON NEXT PAGE)
<table>
<thead>
<tr>
<th>Service</th>
<th>Satisfied</th>
<th>Neither Satisfied nor Un-Satisfied</th>
<th>Dissatisfied</th>
<th>Not Applicable to Me</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL AND DRUG COUNSELLING</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>DOMESTIC VIOLENCE COUNSELLING</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>HEALTH COUNSELLING</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>PREGNANCY CARE</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>COUNSELLING FOR PERSONAL PROBLEMS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>FINANCIAL COUNSELLING</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>LEGAL COUNSELLING</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>INFORMATION ON HEALTHY EATING</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

45. Have you heard of the Clovelly Park Community Health Centre on South Road?

**YES [ ]**

**NO [ ]** → **GO TO Q.46**

If YES - Have you ever used any of the services at the Clovelly Park Community Health Centre?

**YES [ ]** *(Please list below the services you have used)*

**NO [ ]** → **GO TO Q.46**

..................................................................................................................
SECTION 5.

46. We would like you to rate certain aspects of the area you live in. To do this, please circle a number between 1 and 5 to show how you rate your area on each of the following factors.

(For example: If you think the area in which you live is very quiet circle (1), if quiet circle (2), neither quiet nor noisy circle (3), noisy circle (4), very noisy circle (5).

<table>
<thead>
<tr>
<th>(a) VERY QUIET</th>
<th>VERY NOISY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(b) VERY CLEAN</th>
<th>VERY DIRTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(c) A VERY FRIENDLY PLACE TO LIVE</th>
<th>A VERY UNFRIENDLY PLACE TO LIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(d) A VERY ATTRACTIVE PLACE TO LIVE</th>
<th>A VERY UNATTRACTIVE PLACE TO LIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(e) A VERY SAFE PLACE TO LIVE</th>
<th>A VERY UNSAFE PLACE TO LIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
47. Are there any other comments you would like to make about health, welfare and community services in your area?


48. Have you any comments you would like to make about this Questionnaire?


PLEASE CHECK YOU HAVE ANSWERED ALL RELEVANT QUESTIONS.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE POST THIS QUESTIONNAIRE BACK TO US IN THE ENVELOPE PROVIDED.
Southern Community Health Services
Research Unit

c/o Morphett Vale Community Health Centre, 198 Main South Road, Morphett Vale 5162, South Australia.
Telephone 326 0433

MARION, BRIGHTON AND GLENELG
YOUTH COMMUNITY HEALTH SURVEY

Children and youth represent a large and extremely important segment of the population. They have a highly specific demand for health and community services. If adequate and appropriate facilities are to be provided for them it is vital that we obtain information about their characteristics and needs.

Please Complete The Attached Questionnaire If You Are A Parent, Step-Parent Or Guardian Of A Child Aged 18 Years Or Less

1) ALL ANSWERS WILL REMAIN STRICTLY CONFIDENTIAL.

2) If you have any problems completing the questionnaire do not hesitate to phone the Research Unit (326 0433) and we will either help you over the phone or arrange for someone to come and assist you.

3) When you have completed the questionnaire, please return it with the Community Health Survey in the envelope provided.

THANK YOU FOR YOUR CO-OPERATION
PLEASE ENSURE THAT YOU ANSWER EVERY QUESTION

1. How many children aged 18 years or less do you have? (Please indicate how many are your own, or step-children, or under your guardianship)

   Number
   
   a) Your own children
   
   b) Step Children
   
   c) Children under guardianship

2. For each child, could you please indicate their sex, age and if they live with you all the time, some of the time or not at all.

<table>
<thead>
<tr>
<th>CHILD LIVES WITH YOU:</th>
<th>SEX (M/F)</th>
<th>AGE</th>
<th>ALL THE TIME</th>
<th>SOME OF THE TIME</th>
<th>NOT AT ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. In bringing up your child(ren) how often (if at all) have you used or consulted the following sources for advice?
(Please tick the appropriate box)

<table>
<thead>
<tr>
<th>Source</th>
<th>Very Often</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Family, friends &amp; relatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Doctor (G.P.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Doctor (specialist)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Books, magazines, pamphlets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Child, Adolescent &amp; Family Health Service (CAFHS) including Mothers &amp; Babies Health Assoc. (MBHA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Child &amp; Adolescent Mental Health Services (CAMHS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Community Health Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) School Teacher/School Principal/School Student Counsellor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Hospital: Paediatrics Dept.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident &amp; emergency/casualty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please state)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Dept. of Community Welfare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Child Care Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) Family Day Care Giver</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) Religious person (Priest, Minister, Pastor, Rabbi)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n) Any other sources (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Below are a list of problems parents may have in bringing up their children. If you were faced with these problems, how would you deal with them?

PLEASE ANSWER ALL QUESTIONS, REGARDLESS OF THE AGE OF YOUR CHILDREN.

a) i) Your young child is having behavioural problems, for example: frequently throwing tantrums, fighting with other children.

☐ Deal with problem ☐ Seek advice myself

ii) If you were to seek advice, please state who or what you would consult.

b) i) Your primary school child has recurrent health problems, for example, asthma, ear-ache, etc.

☐ Deal with problem ☐ Seek advice myself

ii) If you were to seek advice, please state who or what you would consult.

c) i) Your child seems to have social problems for example: says she/he has no friends at school.

☐ Deal with problem ☐ Seek advice myself

ii) If you were to seek advice, please state who or what you would consult.
d) i) You suspect your child is experimenting with drugs.
   
   [ ] Deal with problem 
   [ ] Seek advice myself

   ii) If you were to seek advice, please state who or what you would consult.

   ________________________________
   ________________________________


e) i) Your child has been reported for a minor offence, for example: stealing, truancy, vandalism.
   
   [ ] Deal with problem 
   [ ] Seek advice myself

   ii) If you were to seek advice, please state who or what you would consult.

   ________________________________
   ________________________________

f) i) Your child tells you that she or he has been sexually abused by a relative or a close friend of the family.
   
   [ ] Deal with problem 
   [ ] Seek advice myself

   ii) If you were to seek advice, please state who or what you would consult.

   ________________________________
   ________________________________
5. Could you please indicate how serious you think the following problems are, for children and youth, in the area where you live. Example: If you think that poverty is not a problem in your area circle ①, if a quite serious problem circle ②, if a very serious problem circle ③ and if an extremely serious problem circle ④.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not a Problem</th>
<th>Quite Serious</th>
<th>Very Serious</th>
<th>Extremely Serious</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Lack of money</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2) Unemployment or lack of work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3) Drug Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Drinking alcohol</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b) Smoking tobacco</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c) Smoking marijuana/dope</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d) Other drugs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4) Drink Driving</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5) Boredom or nothing to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6) Transport</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7) Nowhere to go for recreation or sport</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8) Nowhere to go for entertainment for example: discos, youth clubs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9) Lack of knowledge about contraception</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10) Lack of help to get jobs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11) Nowhere to take sick children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12) No health care service just for youth</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13) No-one to talk to about personal problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14) Inadequate school facilities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
6. What do you think are the 3 best aspects of your area for children and youth?
   a) ________________________________
   b) ________________________________
   c) ________________________________

7. (a) How safe for your children is the area where you live? If you think it is very safe circle 1, if safe circle 2, if neither safe nor unsafe circle 3, if unsafe circle 4, if very unsafe circle 5.

   1 Very Safe
   2 3 Neither safe nor unsafe
   4 5 Unsafe Very Unsafe

   (b) If you think your neighbourhood is unsafe or very unsafe, what makes it unsafe for your children?

   ________________________________
   ________________________________
   ________________________________

8. Do you have any further general comments you would like to make concerning the provision of health and community services for children and youth in your area?

   ________________________________
   ________________________________
   ________________________________

**PLEASE CHECK THAT YOU HAVE ANSWERED ALL THE RELEVANT QUESTIONS**

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE**

**PLEASE POST THIS QUESTIONNAIRE, ALONG WITH THE OTHER QUESTIONNAIRE, IN THE ENVELOPE PROVIDED.**
APPENDIX 1.5

Community consultation guidelines for MARBRIG Community Health Needs Assessment
GUIDELINES

MARION, BRIGHTON & GLENELG

COMMUNITY HEALTH NEEDS ASSESSMENT

COMMUNITY CONSULTATION

THESE SHEETS ARE TO HELP YOU IDENTIFY HEALTH AND SOCIAL PROBLEMS IN MARION, BRIGHTON AND GLENELG
THE MARION, BRIGHTON AND GLENELG COMMUNITY HEALTH ASSESSMENT IS A RESEARCH PROJECT DESIGNED TO IDENTIFY THE HEALTH PROBLEMS AND NEEDS OF RESIDENTS IN THE THREE COUNCIL AREAS.

THE SOUTHERN COMMUNITY HEALTH SERVICES RESEARCH UNIT WILL BE COLLECTING INFORMATION IN A SURVEY OF RANDOMLY SELECTED RESIDENTS IN THE THREE COUNCIL AREAS.

ADDITIONAL INFORMATION WILL BE PROVIDED BY HEALTH, WELFARE AND COMMUNITY WORKERS ON SPECIFIC TOPICS.

TOPICS COULD RANGE FROM "ISOLATION" TO "THE PROBLEMS FACED BY CARERS OF OTHERS" OR ANY OTHER PROBLEMS YOU FEEL AFFECTS PEOPLE'S HEALTH. THESE PRESENT GUIDELINES PROVIDE A FRAMEWORK FOR PARTICIPANTS TO PRESENT THE INFORMATION THEY COLLECT.
PROJECT NAME:

ON WHAT SUBJECT AREA ARE YOU COLLECTING INFORMATION?

WHOM HAS THE MAIN RESPONSIBILITY FOR COLLECTING THIS INFORMATION?

WHO ELSE IS CONTRIBUTING?

PROMPTS
• NAMES
• TELEPHONE NUMBERS
• WHERE FROM?
• AREA(S) OF INTEREST
PROJECT NAME

PROBLEMS AND/or NEEDS

WHAT PROBLEMS DID YOU IDENTIFY?
WHAT NEEDS DID YOU DISCOVER?

FINDINGS 1

DONT’ FORGET THE DETAILS!

EXAMPLES?

ANECDOSES?

NEED MORE ROOM? TAKE ANOTHER SHEET
FINDINGS 2

PROJECT NAME

This is the hard part! Fill it out the best you can...

IDENTIFY SPECIFIC PROBLEM OR NEED:

IS THIS PROBLEM OR NEED CURRENTLY BEING ADDRESSED?

☐ NO

☐ YES → Skip to FINDINGS 3

DO YOU KNOW WHY THERE IS NO APPARENT ACTION ON THIS PROBLEM OR NEED AT PRESENT?

IS THIS NEED OR PROBLEM UNRECORDED?

HAS IT BEEN PUT IN THE TOO HARD BASKET?

TOO EXPENSIVE TO DO ANYTHING?

OTHER REASON?

USE ANOTHER SHEET IF YOU NEED IT. THEN TURN TO SOLUTIONS!
PROJECT NAME

IDENTIFY NEED OR PROBLEM

YOU HAVE SAID THIS PROBLEM OR NEED IS CURRENTLY BEING ADDRESSED — BY WHOM OR WHAT?

LIST AGENCIES. WHAT RESOURCES ARE GIVEN TO IT? — ACTION PLANS IF KNOWN

WHAT ARE THE POSITIVE ASPECTS OR OUTCOMES OF THE PRESENT APPROACH(ES)?

IS THE PRESENT PROGRAM ADDRESSING THIS PROBLEM OR NEED SUFFICIENT?

IS THE PROBLEM OR NEED BEING APPROACHED IN THE WRONG WAY?

IS THERE A LACK OF RESOURCES?

WILL THE PROBLEM BE SOLVED OR THE NEED MET WITH PRESENT ACTIONS AND RESOURCES GIVEN TIME?

USE ANOTHER SHEET IF YOU NEED IT — THEN TURN TO SOLUTIONS!
LEFT OVERS

ANYTHING ELSE?

PROMPTS

Is there a need for further investigation?

Do you need more information?

Is there anyone else you want to talk to?

Any misgivings?

Remember - it's still too early for solutions - that's the next step!
SOLUTIONS

WHAT ACTION DO YOU THINK SHOULD BE TAKEN ON THIS NEED OR PROBLEM?

ANY IDEAS – NO MATTER HOW ROUGH
DIRECTIONS TO GO?
ANY RECOMMENDATIONS?
APPENDIX 3.1

Table of random numbers and explanation

The table of random numbers on the next page was taken from Bailey 1978: 444-6. Notice that the rows and columns are grouped into fives: this is only to make it easier to read the table. Thus, the first row commences 100973253376 ... and the first column commences 13091638 ... etc. The method for using the table is as follows.

First decide whether you wish to go down columns or across rows - it does not matter. The particular row or column you begin with also can be selected arbitrarily - you should not always commence at the first column or row.

If your population size is, for example, in the thousands, take the first four digits of the column or row you have selected and, if the resulting number is no greater than your population size, include it in your sampling frame. If you should come across the same number again, you simply ignore it and select the next number. Continue this selection procedure until you have the sample size you require.
APPENDIX 3.2

Letter mailed out with MARBRIG questionnaire

Southern Community Health Services
Research Unit

c/o Morphett Vale Community Health Centre, 198 Main South Road, Morphett Vale 5162, South Australia. Tel. 326 0433


Dear Resident,

We are seeking your help with a survey we are conducting. The survey is being done to help plan health and community services in your area. Your responses will help us to provide better health services that are more relevant to your needs.

Your name and address is included in our sample, because it came up as one of those selected AT RANDOM from the Electoral Register. It was selected entirely by chance.

The more responses we receive the more useful the survey will be; so it is important that we receive a reply from you. The questionnaires should only be filled in by the person to whom they are addressed.

You will find two questionnaires in this envelope. One is for you to fill in with information about YOU. The other is for you to fill in ONLY if you are the parent or guardian of a child under 18.

Any information you give us will be treated with full confidentiality. A report of the survey will be written, but it will not identify any individuals.

If you have any questions about the survey, or if you would prefer to fill in the questionnaire over the phone, or by someone visiting you at home, please contact me or another member of the research team by telephoning 326-0433.

Your co-operation is greatly appreciated.

Yours sincerely,

Frances Baum

Frances Baum (Dr.)
Director - Research Unit
APPENDIX 3.3

Cover of MARBRIG questionnaire

Southern Community Health Services
Research Unit
6/8 Morphett Vale Community Health Centre, 196 Main South Road, Morphett Vale 5162, South Australia.
Telephone 326 0433

MARION, BRIGHTON and GLENEIG
COMMUNITY HEALTH SURVEY

Please Read The Following Instructions Before Answering The Questions:

1) We have made the questionnaire as short as possible. Each question has been selected specifically to measure the need for health and community services in your area.
2) It should take approximately 20 minutes to complete.
3) Please complete ALL the questions.
4) YOUR ANSWERS WILL REMAIN STRICTLY CONFIDENTIAL.
5) If you have any problems completing the questionnaire please phone the Research Unit (326 0433) and we will either help you over the phone or arrange for someone to come and assist you.
6) Please try to complete the questionnaire as soon as possible as this will save us sending you reminder letters.
7) When you have completed the questionnaire, please return it in the envelope provided.

THANK YOU FOR YOUR CO-OPERATION
WE HOPE THAT YOU ENJOY COMPLETING THIS QUESTIONNAIRE

Postcode
Questionnaire No.
APPENDIX 3.4

First and second reminder cards - MARBRIG
Community Health Needs Assessment

Dear Resident,

Last week a questionnaire about health and community services in your area was posted to you.

If you have already completed and returned it to us, we would like to thank you.

If not, please do so today. For the survey to be of maximum use to us it is important that we receive a reply from each person who received a questionnaire.

If for some reason you did not receive the questionnaire, or it has been misplaced, please telephone me now (326 0433) and I will post one to you immediately.

Yours sincerely,

Frances Baum (Dr)
DIRECTOR RESEARCH UNIT
(A part of the South Australian Health Commission)

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January, 1988

Dear Resident,

Before Christmas a questionnaire about health and community services in your area was posted to you.

I realise this is a very busy time of the year, but we hope you will be willing to help us by completing the questionnaire.

If you have already completed and returned the questionnaire to us, we would like to thank you.

If not, please do so today. For the survey to be of maximum use to us it is important that we receive a reply from each person who received a questionnaire.

If for some reason you did not receive the questionnaire, or it has been misplaced, please telephone me now (326 0433) and I will post one to you immediately.

Yours sincerely,

Frances Baum (Dr)
DIRECTOR RESEARCH UNIT
(A part of the South Australian Health Commission)
APPENDIX 3.5

First reminder letter - Lower North Community Health Needs Assessment

DID YOU GET ONE OF OUR QUESTIONNAIRES?

WHY NOT FILL IT OUT TODAY?!
AND RETURN IT AS SOON AS POSSIBLE TO:

THE LOWER NORTH COMMUNITY HEALTH NEEDS ASSESSMENT
C/- 198 MAIN SOUTH ROAD, MORPHETT VALE S.A. 5162
OR HAND DELIVER TO THE CLARE COUNCIL CHAMBERS
Dear Resident,

In November I wrote asking you to take part in a survey about health and community services in your area.

You will remember that we are undertaking this study to improve health and community services in your area and to help make these services more relevant to the people who use them.

The success of the survey depends on as many people as possible returning the questionnaires. So could you please take the time to complete the questionnaire? If you prefer, a member of the research team could help you to complete it, either over the phone or in your home. Please telephone me (326-0433) if you would prefer this.

If you have already completed and returned your questionnaire, thank you; and we are sorry to have bothered you again.

In the event that your questionnaire has been misplaced, a replacement is enclosed.

Thank you for your assistance.

Yours sincerely,

Frances Baum
Director - Research Unit
APPENDIX 3.7

Questionnaires for special groups: a case-study of collaborative research.

At times, community researchers may be approached by representatives of a particular ethnic or racial group, who invite them to collaborate in research specifically aimed to tackle issues of vital concern to that group. Such a group may have little research experience.

The following is an example of how a recent social health project (Radford et al. 1990) was conducted at the request of, and in partnership with, the major field-based Aboriginal organisation in Adelaide, the Aboriginal Education Foundation of South Australia Inc (AEF). The AEF is in regular contact with other Aboriginal organisations and, through informal networks developed over some decades of service provision, with about 850 Aboriginal households in Adelaide, for educational and family support purposes. As this project spanned a few years and involved the commitment and resources of several members of the Department of Primary Health Care at Flinders University in Adelaide, together with most staff of the AEF, its scale may be considered beyond the resources of a smaller project. However, most of the steps taken in the AEF research project are fundamental to research of a field-based, cross-cultural type, regardless of scope or time-span.

To understand the project, and how it came to be focussed around in-depth interviews using questionnaires, some background is needed. This study originated in response to four Aboriginal suicides within one month in Adelaide, and the subsequent desire to understand, and to intervene to reduce such destructive behaviour. The suicides were mostly among Aboriginal single mothers with young children. This was profoundly disturbing to the Aboriginal community and to the staff of AEF.

AEF correspondence (Power 1987) at the time identified the dangers of disseminating too many tranquilisers in Aboriginal communities, and showed that the AEF moved quickly to involve all relevant organisations, including the medical profession.

Such correspondence proved invaluable to the research team, as it got to the heart of the community's concerns, and provided the basis of subsequent project objectives.
Minority cultural groups sometimes feel they have been the subject of too much research, research that has been conducted 'on them', rather than 'with them'. The Aboriginal community is no exception.

The research agenda is usually set by the commissioning organisation and, for ethical reasons, the task of the research team must be to design a project faithful to that agenda. In the early stages of the AEF project, every effort was made to involve persons who would agree to refer the decision-making processes back into the Aboriginal communities via the AEF, so that control remained there, despite the collaborative nature of the research.

As this Manual frequently reminds us, everyone possesses values and attitudes of their own, even those who have been trained in research techniques. Furthermore, those research techniques embody philosophical and theoretical assumptions which may clash with, or be insensitive to, the values of members of the commissioning organisation. This may not be realised by the organisation for quite some time. For example, the research team may consider it appropriate to refer to its track record of research, which may lie almost exclusively within a quantitative research orientation, with its 'data-entry/data-coding/data-analysis' framework. The commissioning organisation, possessing little research experience, may happily leave such research design details to 'the experts'. But such a research framework may be in some ways inadequate for exploring the social health dimensions of the group concerned.

Therefore, it is the job of the research team, which should include members of the commissioning organisation, to make every effort to ensure that the methodologies adopted are appropriate to the issues being researched, and to the people or ethnic group that is the focus of the study.

Designing a good questionnaire is never as simple as it sounds. A questionnaire is primarily about communication, not primarily about 'yes' and 'no', and ticking boxes. Therefore, the most important task is to discover as much as possible about communication within the special group that is the focus of our concern. This may involve an understanding of language barriers, the cultural meanings attached to the key words that are likely to be used and explored during the course of the research, gestures and mannerisms, written works and cultural symbols, and special meeting places. We must not assume that such meanings or cultural expressions are uniform throughout the group, nor even that our carefully-chosen interviewers understand the same thing by the same terms - let alone their interviewees. Careful and systematic
qualitative research into all of these issues will be fundamental to the success of a project, even if it remains primarily a quantitative one.

Planning the Aboriginal Social Health Study

When the AEF sought assistance from the Department of Primary Health Care, Flinders University, to conduct the research, a considerable amount of time was spent discussing:

- the focus of the research, and the primary objectives and desirable secondary objectives of the project;
- the attitudes to, and perceptions of, the subjects of the research (violence, destructive behaviour, suicide attempt, etc.) within the culture and its social setting, together with key words and concepts;
- the socio-cultural context of the fieldwork; for example, in Aboriginal households, ‘chatting over a cuppa’ around the kitchen table is the main context of communication, with kids coming and going, and other family members dropping in;
- how to ‘tap in’ to the information and insights of the Aboriginal representatives;
- who was to be interviewed;
- the various possible outcomes of the research.

The decision to use only one ‘standard’ questionnaire was due to the suspicion that is felt by Aboriginal people when confronted with standard ‘mental health’ questionnaires. This decision was a compromise: some team members wanted to obtain as much quantifiable information as possible and believed that ‘numbers can be used to great effect to persuade the powers that be’. However, the distrust of statistics, and in particular of ‘psychological test’ type questionnaires, felt by members of the Aboriginal community, and the extreme sensitivity of some of the topics of research, suggested that the use of a highly structured questionnaire format was inappropriate.

Further, it is unlikely that any ‘special group’ possesses a homogeneous outlook on the whole range of matters that are to be the focus of research.

Therefore, in order to explore as wide a range of experiences as possible, many questions included an open-ended component, which resulted in the semi-structured nature of the final research
instrument. 'It was agreed that simply to ask closed-ended questions would threaten the validity of our results'.

The next step was for the research team to devise a simple topic sheet to use in pilot study interviews and to explore these topics with at least ten Aboriginal households using interviewers who had been specially selected for their acceptance by Aboriginal people. The topics included:

- knowledge of parents, family and kin relationships, and support;
- employment and education;
- income, income source and any financial difficulties;
- housing - mobility, tenure, rental;
- access to transport;
- health services used, and satisfaction with these;
- institutionalisation, and interaction with the law and imprisonment;
- violence, physical and sexual abuse, self abuse;
- perceptions of stress;
- perceptions of 'how getting on . . . generally';
- perceptions of racism and prejudice, and acceptance in the wider community; and
- perceptions of achievement and things which bring pride.

The results of the pilot interviews were assessed in consultation with AEF. Those issues which were felt by Aboriginal care-givers to be the most important were identified, and a semi-structured interview schedule was developed that would hope to capture the wide range of views arising out of the pilot interviews, while at the same time allowing considerable quantification.

The Interview Schedule

The final semi-structured questionnaire resulted from many drafts which were the subject of numerous meetings of the research team and further tested in the field.

By answering carefully designed and ordered questions, respondents described their life circumstances, personal histories, particular experiences of destructive behaviour, their perceptions of society and of their place within it, and the achievements of which they felt proud.
With regard to the interview itself, the research Monograph which explains the methodology in detail (Radford et al. 1990:41), reads:

[For the final interview of the random sample], interviewing teams were all female and most were pairs. In each pair, a staff member of AEF ... teamed with a member of the Aboriginal community. Interviews proceeded at a pace determined by the respondent, and in a style that permitted different ways of response. Interviewers were instructed to let the answers emerge from discussion rather than pursue answers in an interrogative and direct manner. Their aim was, wherever appropriate, to develop legitimate and authentic interview/discussions around the major topics, which would permit the interviewer to answer ‘closed’ questions on the questionnaires, and to add qualitative information to build aspects of the ‘life-story’ of the respondent around the closed questions. The interviewers were instructed to complete each section in a methodical manner, but not to be entirely limited by the interview format ...

The interview/discussion occupied 2-4 hours for its completion, and took place mostly in the respondent’s home. The longer interviews were generally those where the respondent needed time to establish rapport with the interviewing team, and/or time to ‘talk out’ the more sensitive topics of discussion. A return visit was sometimes necessary for respondents with complex and/or difficult life-histories, as it was for some with young children in the home. Both the mode of conducting the interviews, and the content, were widely accepted by responding families.

The coding scheme for computer analysis was not included in the questionnaire but was developed much later, after draft-coding of a considerable number of interviews was completed. Coding for the Aboriginal project had to be carried out by a research officer, and not by clerical staff, as it was often ‘conceptual’ coding (Labaw 1980) that was required. This also made it possible to check the consistency of interviewer recording, emerging aspects of family structure, and perceptions of the wider society.

The Comparative Component of the Study

The study design for the Aboriginal project incorporated a very important element: that of a comparison group. In field research of this kind, it is very difficult to know to what extent the experience and perceptions of any ‘special group’ differs from that of the wider community. Certainly there are difficulties in selecting a comparison group and one may have reservations about
interviewing such a group with a schedule which has been designed primarily for the ‘special group’. However, it is preferable to have a comparative perspective, as it helps us to gauge the special experience, and hence the special needs, of the ‘special group’. For the Aboriginal project, a comparison was made of Aboriginal and non-Aboriginal single mothers in rented government housing.

Interpretation of results

The interpretation of research results needs to be discussed with representatives of the special group being studied, who may then stimulate discussion amongst others in the group. This is not simply to inform those members (i.e. to provide feedback), but to gain an understanding of their perceptions of the results as they emerge. They may demand for example, that some key aspects be taken back to the drawing board, or that they should remain confidential.

At the completion of this process, the results of the study are made available to all the appropriate ‘special group’ organisations and to relevant government departments.

Subsequent action arising from the results of such research then remains the prime concern of the group that commissioned the research, who may or may not choose to involve members of the research team as the need arises.
APPENDIX 5.1

Cartoons in MARBRIG report

Unemployment, by contrast, brings with it considerable health costs, both physical and psychological. People who want paid employment and cannot get it are likely to feel frustrated, undervalued and may lose their sense of worth. In addition, they are usually living in poverty.

In Marion, Brighton and Glenelg the main group suffering this problem are the young. Figure 4 shows the proportion of the workforce who were unemployed at the time of the survey, for each age-group and sex. This shows that the burden of unemployment falls heavily on the 17-24 year olds, particularly young women. The problem of youth unemployment is dealt with in more detail in the Youth Report.
The most likely explanation is that it costs money to go to the dentist, whereas a test of blood pressure or cholesterol level is often free and is carried out as a clinical test as well as for screening. It may also be that the state of one's teeth is seen as a more 'cosmetic' health concern than blood pressure or cholesterol. Certainly Medicare covers visits to General Practitioners who will perform blood pressure or cholesterol tests, but does not cover dental care. Those on higher incomes are more likely to have insurance cover or be able to pay for dental visits.

A similar pattern emerges, as would be expected if levels of education and income are assumed to be related, for the relationship between level of education and frequency of tests. Fig. 12 shows the frequency of blood pressure, dental or cholesterol checks.
APPENDIX 5.2

Press release for MARBRIG 'Youth Report'

PRESS RELEASE

1/3/1989 (give to Messenger Thurs 22)

REPORT RECOMMENDS MORE EMPHASIS ON YOUTH

Increased awareness of the needs of young people, an investigation of young people's perceptions of the health hazards of smoking and drinking, support for contraceptive education, and a youth cafe, are some of the recommendations of a report released today on the young people in the southern suburbs on Marion, Brighton and Glenelg.

The report, the second of four reports on the health of residents in Marion Brighton and Glenelg produced by the Southern Community Research Unit, part of the Health Commission, was launched today at the Mitchell Park Neighbourhood centre by Susan Lenerman, representing the Minister for Health Frank Blevins.

The Youth Report, which used a wide range of research techniques including a survey of residents, focused on factors that directly or indirectly affect the health of young people.

"One unexpected result was the finding that more young people than older people suffered from minor illness such as colds and stomach trouble and from stress related illnesses such as headaches and depression" Chris Gallus, the research officer responsible for the report said today.

"The survey of residents of the three council areas also showed a continuation of the trends we have been observing over the last few years of increasing cigarette consumption by young women."

"Our survey showed that for the first time young women are edging ahead not only of young men but of all other age groups of either sex."

"We think it is pertinent that this higher incidence of smoking amongst young women comes at a time when cigarette companies are specially targeting young women with their advertising."

"Another disturbing trend was the high level of preference for spirits amongst young people. Questioned about what they usually drank, almost 60% of young people said spirits. This is far higher than preference for spirits in any other age group and confirms what community workers have been telling us about youth drinking."

A major finding of the report was that young people in the southern suburbs needed places where they could meet, preferably where alcohol was not available.

The report suggests adopting the French idea of a youth cafe which provides low cost cheap food and drink to young people while serving as a place where they can meet and 'hang out' without being pressured to move on after they finish their meal.
Invitation to Health Issues Day, Noarlunga

NOARLUNGA
"HEALTH ISSUES DAY"

Saturday June 14th, 9.30-4.30p.m.

NOARLUNGA HEALTH VILLAGE, ALEXANDER KELLY DRIVE, NOARLUNGA CENTRE.

Come along and have your say. We will be discussing among other things:

* The proposed new hospital and the services it should provide
* How life in Noarlunga affects your health
* What type of action is needed to make Noarlunga a healthier place to live.

And lots more aspects of health and life in the Noarlunga community.

SEE YOU THERE!