



# **RAPID ASSESSMENT PROCEDURES FOR THE STUDY OF FOOD HABITS AND HEALTH STATUS IN THE ELDERLY**

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## **ACKNOWLEDGEMENTS**

This Field Guide has evolved over several years. It began with interview check-lists (guides) and specific methodological examples developed by Susan Scrimshaw for Chloe O'Gara for research on infant feeding patterns in Honduras in 1981. It grew considerably in Guatemala in 1983 under the direction of Elena Hurtado and Susan Scrimshaw with Germana Sanchez and Aracely Espuivel working on an INCAP project on Health Seeking Behaviour funded by the United Nations University. The methodology was refined through research at INCAP in 1983 and formed the nucleus for the December 1983 Workshop in Geneva, Switzerland sponsored by the UNU and UNICEF to develop a methodology for the study of health-seeking Behaviour at the household level. The manual as revised in that workshop was edited and then published (Scrimshaw and Hurtado, 1984). In 1984, components on diarrhoeal disease, infectious diseases, and growth and development were added at INCAP. Elena Hurtado and Susan Scrimshaw also developed the check-lists for health care providers as part of an INCAP project on child survival. The revised manual was then tested and further modified in a two week training course for 15 Central American social scientists held at INCIENSA in Costa Rica in April of 1985. It was then discussed and revised at Bellagio, Italy in 1985 at the UNU-UNICEF workshop to discuss the previously collected data on health-seeking Behaviour and to design methods for studying health care providers. The section on Focus groups is based on one developed by Betty Booth of the Academy for Educational Development for the PROCOMSI project in Honduras and her permission to edit and publish it here is gratefully acknowledged.

The current version is based on revisions resulting from these multiple experiences, and examples drawn from the IUNS study. We expect that it will continue to evolve. Through all the versions of this guide since the early work in Guatemala one individual's vision has guided us, prodded us, and procured funding from the United Nations University and UNICEF for the field work in many countries which served as its testing ground and for the workshops which contributed to its development. Without the energy and vision of Dr. Nevin Scrimshaw, this

work would not exist.

## 1. INTRODUCTION

Anthropologists traditionally spend many years learning the culture of their discipline and many more years understanding other cultures. It is only recently that anthropologists have brought their methods and theoretical perspectives to bear on such questions as the evaluation and improvement of primary health care services (Paul 1955). One obstacle has been the long periods spent in the field and the large accumulation of theoretical material required by ethnography. Another has been that the theoretical concerns of anthropology have not been those of applied health or nutrition programmes. Although the ideal ethnography may be built from both of these elements, a great deal of practical, diagnostic and applied work can be accomplished in a shorter time and by using a simpler approach.

Rapid Assessment Procedures (RAP) provides health workers, researchers and social scientists in fields other than anthropology and anthropologists with guidelines for conducting rapid assessments of health seeking behaviour involved in maintaining health and overcoming illness, including the use of both traditional and modern health services. One does not need an advanced degree in anthropology to use the guide. One does need organizational skills and, most important, the ability to develop rapport with people and to accurately record and transmit their views, beliefs, and behaviours.

The guide does not provide detailed descriptions of basic anthropological techniques. It does, however, suggest appropriate topics for data collection on health seeking behaviours. Data collection guides are presented for each topic (Section 4.1). The guides are designed primarily for short periods of data collection, in the range of four to eight weeks, but they can readily be expanded for longer-term application, resources permitting.

As mentioned, the approach presented here differs from traditional anthropology in that it involves a relatively short time in the field and focuses the research on a few specific topics such as health care providers and households. Since qualitative and quantitative researchers argue over issues of reliability (the replicability or representativeness of data) and validity (the extent to which one is measuring what one purports to measure), the rapid assessment using anthropological techniques proposed here would seem even more open to criticism. The issues of the types and values of findings using various methods have been discussed elsewhere (Dewalt and Pelto 1985; Pelto and Pelto 1978).

Obviously, the type of information needed is an important consideration. Epidemiological information, such as the prevalence of heart disease in a population, will require quantitative survey techniques. Reliable information about food habits of older people such as food preparation, foods stored and food purchasing may best be obtained with more qualitative anthropological techniques and through observation.

To a surprisingly large degree, health programmes have been introduced with no culture specific 'maps' at all. Western biomedical systems developed in the United States and Europe have been applied to developed countries without sufficient critical examination of local conditions and peoples. 'Maps' such as those generated using anthropological methods can help to improve the 'fit' of programmes to people.

The importance of the information collected by RAP may best be understood by a map analogy. RAP can provide information about the *presence* of beliefs and behaviour rather than the exact *proportion*, analogous to rivers and mountains, without knowing the *depth or velocity* of a river or the *precise height* of a mountain. Nevertheless, a good 'picture' is still obtained in such a short period using small samples, which allows one to draw qualitative conclusions. For some programmes, however, it may still be necessary to include quantitative survey methods to obtain broader numerical information about a topic.

Interventions may lead to less potential advantage in later life in respect to total years of life gained or reduction in morbidity achieved than in earlier life. Therefore, disadvantages involved in any assessment approach monitoring programme or interventions which arise from these, must be few (WHO, 1989). The relatively low cost and level of interference of the RAP approach, compared with detailed enquiry and investigation, is an advantage. In the setting of later life, an added advantage of RAP is that it does not presume outcome and would allow the detection of the unexpected health, social or other consequences of intervention where other methodologies may not. For example, the change in sodium intake to deal with hypertension may lead to a variety of food and non-food changes in an elderly community which might not justify the intervention, but whose recognition might be difficult.

A combination of both RAP and questionnaire approach can be highly recommended, especially for gathering data on food beliefs which require open ended questions (Kouris et al., 1991; Wahlqvist et al., 1991). RAP is also very useful with non-literate communities, where group enquiry may be more valuable than individual enquiry (Wahlqvist et al., 1991; see also Chapter on Aboriginal Australians) and where a questionnaire approach for individuals may later be applied.

**Table A2.1. Ability to recognise the tradeoffs in intervention programme using RAP for monitoring processes.**

**Advantages**

- minimal intervention
- ability to detect novel changes in morbidity and ability to consider unusual or unexpected changes in mortality events

**Disadvantages**

- degree of dislocation by this or any other enquiry

- data are less quantitative than might be needed for confidence about change

**Table A2.2. Comparison of RAP, questionnaire, or combined approaches.**

	<b>RAP</b>	<b>Questionnaire</b>	<b>RAP+Questionnaire</b>
<b>Advantage</b>	Not presumptive Non-judgemental More tailored to community	Pre-coded	Not presumptive
<b>Disadvantage</b>	Not coded	Presumptive	

When the earlier version of RAP (Scrimshaw and Hurtado, 1984), was used in sixteen countries, there were some consistencies in the findings at the study sites (Scrimshaw et al., 1987). For example, rudeness on the part of the government health services staff was a deterrent to the use of services in most of the communities studied. It would hardly require a large survey to know that staff-patient relationships need to be improved in at least those countries.

The above discussion explains in part the uses of data on a few families in one or only a few communities. The question of generalization is an important one, and must be considered in the national context. A country such as Nigeria with several tribal groups, might require information from at least one community representing each group, with verification in other communities using focus group techniques if at all possible. It is important to note, however, that many conclusions have been drawn and programmes planned based on data from one community or a small region. The famous Framingham study in Massachusetts is a case in point (Kannel and Gordon 1968), as is the Alameda County Health Behaviour Study in California (Bellock and Breslow 1972).

## **2. RESEARCH GOALS**

It is the expressed objective of world-wide health professionals and organizations involved with aging populations of the world, to develop a means of identifying the levels of knowledge and information held in communities, about the normal process of aging as well as about preventive and therapeutic measures available to help older people cope with disease and disability.

In the effort to achieve this goal it is important to understand how health care programmes for the elderly interact with people's perceptions, beliefs and behaviours related to health and illness, and nutrition, and how such programmes are influencing older people's health-seeking behaviour. The major purpose of the research guided by this manual will be to analyze the impact of existing public and private programmes on the perceptions, beliefs, knowledge, and

health-seeking behaviour of representative elderly people living in populations served by these programs.

The term 'elderly' is a general term requiring definition. The 'young old' show little signs of ageing (but may have chronic diseases), are capable of doing most activities of daily living and are normally aged between 70-80 years. The 'old old' tend to be frail, more dependent and aged over 80. These are only broad groups and subject to exceptions - such as very fit 90 year olds with no signs of ageing. The survey approach used to study the elderly must be sensitive to these two broad groups, one being largely independent and the other dependent. Additionally, in communities where average life expectancy is in the 50's or 60's, another definition of 'elderly' is required. In this case the upper age decile of the population may be required to obtain an 'elderly' sample.

It will be necessary to collect data from older people, (and their families and caretakers) that:

- 1) Describes the existing health and nutrition knowledge, beliefs, and practices of older people who:
  - a) live independently either alone or with partner, sibling or peer (more prevalent in developed countries)
  - b) who live in institutions (i.e. nursing homes, geriatric centres, retirement villages)(more prevalent in developed countries)
  - c) live with extended families (more prevalent in developing countries)
- 2) Analyse what factors affect older people's perception of geriatric health care programmes cross culturally.
- 3) Examine how and to what extent the various health resources available to older people, particularly the geriatric physical and mental health care system, have affected their understanding of health and illness and their health-seeking behaviours.

### **3. PURPOSE OF RAP**

The purpose of this guide is to improve understanding of the normal processes of aging, the knowledge and beliefs about nutrition, diseases and disabilities of older people cross culturally, and to assess utilization and influence of geriatric health services world-wide.

At the turn of the century, infectious diseases such as tuberculosis and pneumonia were the main causes of death in adults, (in industrialized countries). Medical advances in the past eighty years, such as the discovery of penicillin, and the development of vaccines have accompanied an emphasis on the links between sanitation, hygiene and public health. As a result, people are living well into their sixties, seventies, eighties and nineties in many countries of the world. As people grow older, the health care profession's attention has turned towards the challenge of

understanding and treating chronic diseases and disabilities, and to help the elderly adjust to changes in their senses and physical and mental functioning.

Health and nutrition problems of the elderly in varied cultures need to be addressed by health services in ways which are acceptable, and affordable to the older populations they serve. Part of the challenge of geriatric health providers, is to distinguish between normal aging and more serious disabilities and disease affecting older people.

Some preventive measures have been identified which help in reducing older people's morbidity and mortality:

- a) Food and nutrient intake for the prevention of chronic diseases (e.g low fat, high carbohydrate and fish diets for the prevention of heart disease). Diseases or disorders which are often associated with ageing could be caused by inadequate nutrient intake and certain medication (e.g low folate intake and memory, vitamin B12 and B6 and neuropathy, vitamins C, E and cataracts).
- b) Regular exercise to maintain appearance and functioning
- c) Personal hygiene
- d) Careful planning of living environment to reduce incidence of falling and accidents (e.g. discourage housing with many stairs, install support bars in bathrooms and showers, kitchens)
- e) Encouragement of living or socializing with others to decrease loneliness, feelings of worthlessness
- f) Improve health care accessibility

#### **4. USING RAP**

This field guide provides a methodology for collecting information about older people's experiences, attitudes and beliefs about nutrition and health.

The data collection guides are grouped into four categories:

1. Community
2. Household
3. Older person
4. Primary health care providers.

The guides are intended to help focus the research, organize the data collection process, and standardise the information gathered. They should be used as outlines for the formulation of questionnaires, check-lists, and other data collection instruments. They should be adapted to relate to the needs of the project. Attempts should be made to collect a manageable amount of data. Collecting unnecessary data can be distracting and time-consuming. The information collected should be recorded on separate pages or in field notes.

The data collection guides assist in the gathering of information about the elderly's eating habits, preventive health behaviour, self care and self-medication knowledge, awareness and sharing about their day to day limitations and illness symptoms, and utilization of and attitudes about senior or group recreation centres, health centres and psychogeriatric services which aim to meet the challenge of treating the above mentioned concerns afflicting older people throughout the world.

## **4.1 DATA COLLECTION GUIDES**

### **4.1.1 Community**

General descriptive information should be obtained on the community and include the following if available (adapted from Rapid Assessment Procedures, Scrimshaw and Hurtado, 1987) (see also IUNS protocol).

#### *4.1.1.1 Geographic Characteristics*

Bibliographic research, observation:

- a. community type- urban, suburban, semi-rural, rural, dispersed, compact
- b. type, availability and cost of public transportation (train, bus waterway, other)
- c. distance from home to urban centres (social centres, clinics, market)
- d. topography
- e. climate, seasons
- f. map (if possible) -area, boundaries, roads, features
- g. history of the community

#### *4.1.1.2 Demographic and epidemiologic characteristics*

Interviews with key informants/ authorities, observation, bibliographic research.

- a. population size ('usual' at time of study")
- b. age pyramid of population with special attention to proportion of population aged 40-49, 50-64, 65-74, 75-84, 85+; proportion of elderly to total population .
- c. birth rate and child mortality rate
- d. mortality and morbidity across all ages, especially for those aged 70-79 and 80+ - major causes of death, disease prevalence, life expectancy at age 70

- e. ethnic groups (identify)
- f. sex distribution (male/female)
- g. age distribution
- h. economically active population (per cent by age and sex)
- i. migration patterns (seasonal for work, rural-urban, etc.)
- j. languages spoken and written
- k. religious groups

#### 4.1.1.3 *Socio-economic characteristics*

Interview key informants/authorities, observation, bibliographic research

- a. community organization- local authorities, leaders, groups (religious, clubs, occupational), sanitation, water supply
- b. domestic/household organization- nuclear vs. extended, residence patterns, land sharing by family members
- c. economic characteristics- major employers, major activities (male/female), unemployment and underemployment, per capita income, distribution of wealth, land ownership, access to land.
- d. pensions and other state benefits

#### 4.1.1.4 *Health resources*

Interview key informants/authorities (priests, teachers, mayor), observation. Data on the community may be available at national/and or regional as well as local levels.

- a. health resources used by the community e.g indigenous, modern
- b. types of facilities
- c. transportation to health resources, distance to resource, transportation type e.g foot, bus

### **4.1.2 Household**

#### 4.1.2.1 *Housing Conditions*

Interviews, observation

- a. type of housing- single family dwelling, multiple family dwelling, public housing
- b. description of residences- tent, brush hut, mud
- c. house, materials (walls, roof, floor), compound area (type of surrounding wall), number of rooms
- d. kitchen facilities- gas/electric range, hot plate, wood fire, refrigerator, means of food storage, disposition of garbage
- e. water source, disposition of human waste, electricity, inventory of key possessions (radio, television, bicycle) garden and local (near household) crops

#### 4.1.2.2 *Household Composition*

Interviews with household head and other members

- a. number of persons in the household
- b. number of persons aged over 65
- c. head(s) of household
- d. age, sex, years of schooling, length of residence in community, place of origin, religion, main occupation (past and present)
- e. relationship of each member of household to other members
- f. number of children and grandchildren of each elderly household member

#### 4.1.2.3 *Socio-economic Status*

Interviews, conversations

- a. employment of household member(s) (hours/day, days/week, weeks/year), if retired, state when, and former employment
- b. amount of land owned/rented
- c. amount of land cultivated
- d. amount of food stored in house and means of storage
- e. amount of food sold
- f. number of economically dependent (non-earners of cash income) household members

### **4.1.3 Older person**

Interviews, conversations with caregiver, head of household, focus groups, observation, morbidity and mortality statistics of community

#### 4.1.3.1 *Physical Health status and Health beliefs*

- a) Definitions of health and illness
- b) Common illnesses affecting elderly in community, chronic (e.g heart disease, blood pressure, diabetes, constipation) and communicable diseases (pneumonia) - define time frame i.e past year or life time health/morbidity history
- c) Perceived gravity or seriousness of each illness and cause of illness.
- d) Medications taken for illnesses and herbal/natural remedies
- e) Beliefs about preventing these illnesses
- f) Inventory of household remedies (both folk and 'medical')
- g) Ability of elderly person to answer questions independently and lucidly - enquire about cognitive function of older person from other household members

#### 4.1.3.2 *Foods Eaten and Food Beliefs*

- a) Typical foods eaten over a week (diet history), indicate how may change with seasons. The diet history method is more in line with anthropological methods. It is more flexible than a food frequency questionnaire because it does not have fixed responses and does not make presumptions of types of foods eaten (i.e foods not precoded). Go to local market to obtain information on food availability, seasonality and prices to assist in interviewing.
- b) Record type and time of day foods are eaten to get a description of food pattern.
- c) What foods are appropriate for elderly?
- d) Explore perceived functions of food (longevity, illness, prevention, strength).

#### 4.1.3.3 *Risk Factors for Malnutrition*

A risk factor has been defined as a major identifiable biological or environmental circumstance or event that increases the risk of malnutrition and therefore suggests the need for special care and attention (Davies, 1991). For example:

- low socio-economic status
- housebound/living alone
- nourishing food unavailable/expensive
- insanitary water supplies/pollution
- disaster: eg floods
- lack of community food programs
- disease e.g diabetes/bowel disorders
- poor dentition and/or difficulty in swallowing

In other cultures, other risk factors may be identified e.g low mental test score, clinical diagnosis of depression, chronic bronchitis/gastrectomy.

- a) What are the main environmental circumstances that increase the risk of malnutrition in the elderly?
- b) What are the main biological circumstances that increase the risk of malnutrition in the elderly?
- c) How does one (do you?) draw attention to these circumstances (internationally? nationally? locally?).
- d) How does one (do you?) seek assistance under these circumstances (internationally? nationally? locally?).

#### 4.1.3.4 *Warning Signals for Malnutrition*

Warning signals have been defined as single or groups of observable circumstances that, if left unchecked, might cause an 'at risk' individual to become malnourished (Davies 1991; Davies and Knutson, 1991). For example:

- Recent unintended weight change + or - 3 kg (7 lb)
- Physical disability affecting food procurement, preparation or intake
- Lack of sunlight

- Bereavement and/or observed depression/ loneliness
- Mental confusion affecting eating
- Multiple medications/ long term medication
- Missed meals/snacks/fluids
- Food wastage/rejection
- Insufficient food stores at home
- Lack of fruits, juices, vegetables
- Low budget for food
- Poor nutrition knowledge

Alternative warning signals may be identified e.g.

- Lack of appropriate medicines
  - High alcohol consumption/ heavy smoker
  - Lack of work capacity
  - Poor food hygiene
- a) Which people most frequently visit/care for elderly individuals?
  - b) Are there any simple actions that might prevent/remedy this (these) condition(s)?

#### 4.1.3.5 *Mobility and Dependence*

- a) Activities of daily living - e.g degree of difficulty performing basic functions such as dressing, bathing, cooking.
- b) Exercise - describe daily/weekly activity, including length of time seated/day, time pottering about, time walking etc.
- c) Who is main helper?
- d) Ability to get to places out of walking distance e.g public transport, car, taxi. Need help?.

#### 4.1.3.6 *Social networks and activity*

- a) Does subject live with spouse? Do they rely on spouse for most needs?
- b) Are neighbours supportive/available?
- c) Does elderly subject have a good network of friends? Can they rely on them for anything needed? Who is it? How often are friends seen? Spoken to on phone?
- d) Does elderly subject have a good network of relatives? Can they rely on them for anything needed? Who is it? How often are relatives seen? Spoken to on phone?.
- e) Are contacts with people meaningful or superficial? Do they feel close to anyone? Who? Do they feel lonely?
- f) Describe the social calendar of subject. How often do they leave their home to see friends/relatives or receive visitors?
- g) How is time spent? Reading, knitting, gardening. Describe typical day.

#### 4.1.3.7 *Well-being and Morale*

- a) Is subject bereaved - state number of years?
- b) Feelings of contentness, happiness, depression, satisfaction with life etc.
- c) Interest in life and in living life to the fullest?
- d) Feelings of respect and acknowledgement by their peers/relatives?
- e) Feelings of usefulness?

#### 4.1.4 **Primary health care providers**

##### 4.1.4.1 *Interview with head of Government-sponsored health service(s)*

- a) Services offered: curative, preventative, home visits, laboratory exams, food distribution, health education, dental services, ambulance, hearing tests, eye tests (cataracts).
- b) Personnel: number working full-time and part-time (including volunteers) and their responsibilities.
- c) Equipment, materials, medicines available, hearing aids.
- d) Cost of services and medicines to the patients.
- e) Method of payment.
- f) Utilization: Average number of patients seen daily, normal waiting time, number of patients seen in relation to personnel and equipment, resource adequacy.

##### 4.1.4.2 *Interview with health staff*

- a) Age, sex, marital status, education, ethnic/cultural background of each staff member.
- b) Live in community where service is located.
- c) Professional training. Need for additional training in health field?
- d) Number of years in health field, in health service?
- e) Duties at health centre
- f) Do you like your job? Why? Why not? What gives you most satisfaction?
- g) What do you think are the principal health needs and problems of the community?
- h) What do people of the community think of the health service?

##### 4.1.4.3 *Physical characteristics of health resource*

- a) Describe visual aids and graphic material. What are the messages?
- b) Cleanliness of facility.
- c) Describe light, water, drainage, toilets for staff and patients.

##### 4.1.4.4 *The waiting room*

- a) Number of patients waiting and under what conditions.

- b) Length of time patients wait.
- c) Activities that take place while patients wait.
- d) Interaction between staff and patients e.g forms of courtesy, respect, tone of voice, language, privacy, noise level.

#### 4.1.4.5 *The consultation*

- a) Who interviews/examines patient to gather data on symptoms?
- b) Treatment prescribed and by whom?
- c) Explanations and instructions given to patient - clear and understandable, do they cover what? why? and how? Is the patient asked to repeat the instructions for confirmation? Prescriptions, educational material?
- d) The manner of consultant? Cold, impersonal, neutral, friendly, visual contact, tone of voice, physical contact and effect on patient?
- e) Were patients content with consultation? Why? Why not?
- f) Was elderly patient weighed or questioned about food intake and food storage to detect potential malnutrition (especially those aged 80+ or men living alone)?

#### 4.1.4.6 *Domiciliary care and food distribution*

- a) The provision of home visits to elderly patients? Assessments of homes for safety?. Assessment of homes to detect potential problems of malnutrition e.g storage of food in refrigerator and cupboards, cooking facilities?
- b) The provision of medical aids to elderly patients - eg walkers, rails installed in showers/baths, passage ways etc?
- c) Provision of meals on wheels or volunteers to help with shopping for food and food preparation?

The priorities of geriatric health care have been interpreted or emphasized differently by the health services of various countries so that it cannot be assumed that the services of a given country will include all of the same preventive and therapeutic activities. Hence, interpretation of information on older peoples' responses will depend on the characteristics of the specific geriatric system to which they are exposed.

## 4.2 HUMAN SUBJECTS PROTECTION

Preliminary to the conduct of many research projects it is now common to obtain signed, written, informed consent statements from each individual studied. In social science research, drugs and other treatments are not utilized, but research subjects may be exposed to risks such as emotional distress at discussing sensitive topics or fear that confidential or illegal behaviour will be revealed. Written, signed, informed consent forms are impractical in countries where levels of literacy are low, where documents may symbolise undesired bureaucratic interference, or where

confidentiality is so important that even signing one's name to a document is a risk. The important thing, above all, is not a document, but that the researcher honour the principles of respectful and protective treatment of those individuals studied. Therefore, permission must be obtained at least verbally from: 1) appropriate community leaders 2) families studied 3) caregivers/spouse/relative - particularly relevant when studying elderly who may be living with their family 4) head, owners, or directors of health resources studied 5) individuals studied and 6) others as appropriate.

Whether the permission is oral or written, the researcher must verify that the individual is willing to participate, explain a little about the project, that participation is voluntary, that results will be presented in summary form only and that individuals will not be identified in connection with information about them, and they may cease to participate at any time if they so desire.

The researcher must ensure that confidentiality is maintained and that information is collected and stored so that only authorized people working on the research project have access to it in other than summary or anonymous form. Finally, the researcher must be careful not to make unrealistic promises to the community about the purposes or results of the study. For example, the community should not be told that health services will improve as a result of the study. The researcher should explain that health officials will be given the results and recommendations and it is to be hoped that some improvements will result.

### **4.3 BASIC CONCEPTS RELATED TO HEALTH-SEEKING BEHAVIOUR**

The user will find the methodological discussion in the following chapters and the accompanying examples more beneficial by reviewing these definitions of commonly used terms.

#### **4.3.1 Health-seeking behaviour**

What people do in order to maintain health and/or return to health, ranging from individual behaviour to collective behaviour. It concerns specific steps taken (sometimes called hierarchy of resort) and what is done and why.

#### **4.3.2 Hierarchy of resort**

The process of health-seeking behaviour. It invokes specific steps, such as self-care, then asking a relative, then going to a pharmacy, then going to a health centre. In reality people may go back and forth between resources and use several simultaneously, so 'hierarchy' is a misleading term.

#### **4.3.3 Health care decision-making**

A process of deciding on a course of action in relation to maintaining or restoring health,

including factors and/or people who influence the decision and reasons (explicit and implicit) for the decision.

#### **4.3.4 Outsider/insider**

In anthropological terminology the outsider perspective is referred to as *etic*, the insider perspective as *emic*. This is an important distinction both for data collection and for discussion of results. For example, the concept of 'health' may be an outsider (Western biomedical) concept in some cultures, where a person is seen as 'balanced' ('healthy') or 'out of balance' ('ill') in terms 'hot' and 'cold'. It is useful to work from both perspectives, and to be aware of the distinction.

#### **4.3.5 Community**

Each research project director will need to specify the definition used, because what constitutes a 'community' may vary from country to country. Some examples are groups of individuals with a 'sense of belonging' or individuals in one of the country's administrative units or in the 'catchment area' for a geriatric health programme.

#### **4.3.6. Household**

A group of people who 'share a fire' that is, who share food on a regular basis or who live in a common residence. Food is really a proxy of several economic activities shared by the people who comprise a household. Households usually contain people related by blood or ritual (such as marriage) called families. People who are not members of the family may also live in a household.

#### **4.3.7 Health**

From the outsider perspective, there is the WHO definition which states that health is 'a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity'. From an insider point of view, what constitutes health can vary a great deal from culture to culture.

#### **4.3.8 Disease**

Defined from a Western (outsider) biomedical perspective, disease is an undesirable deviation from a measurable norm. The emphasis here is on signs and symptoms that can be measured with current Western biomedical techniques.

#### **4.3.9 Illness**

Illness is defined in insider cultural terms as the inability to function well in a society the

individual does not feel well and cannot function as usual.

#### **4.3.10 Sick role**

A role an individual adopts (or is made to adopt) when ill, involving altered behaviour in which normal activities are stopped or curtailed and special 'sick behaviours' (such as staying in bed) are carried out instead. Usually, people treat someone in the sick role differently (e.g. isolation or more attention).

#### **4.3.11 Medical system**

The medical system can be conceived of as a) set of cultural beliefs about health and illness that forms the basis for health-seeking behaviour and b) the institutional arrangements within which the behaviour occurs. A distinction is made between the endogenous (indigenous, traditional) health system and the Western biomedical (modern, cosmopolitan) health system. In a community the former is represented by local healers or curers, traditional birth attendants, and the like. The latter is represented by, for example, the official health care programmes with nurses and physicians trained in Western medicine. There is also a lay health care system representing the family-based prevention and treatment of illnesses.

### **5. ANTHROPOLOGICAL METHODS**

#### **5.1 CONDUCT OF RESEARCH**

In the conduct of research on health seeking behaviour amongst the elderly, basic anthropological field methods should be utilized. These methods permit detailed recording of the socio-cultural context in which health-seeking behaviour occurs, in order to better understand and interpret the behaviour. The basic anthropological methods are described below.

##### **5.1.1 Formal interview**

Written questions on specific topics are asked of one individual (respondent); and the responses are recorded in detail.

##### **5.1.2 Informal interview**

Somewhat open-ended questions are asked on certain topics; the researcher follows a general outline, but may incorporate additional subjects as appropriate. The responses may be noted, but are not recorded in detail at the time. They are written up later.

##### **5.1.3 Conversation**

Important data can also be obtained through informal individual or small group conversation. Some people are more at ease in an informal setting and talk more freely.

#### **5.1.4 Observation**

Careful observation of events and behaviour provides valuable non-verbal clues as to what is actually occurring.

#### **5.1.5 Participant observation**

The researcher participates in and observes the socio-cultural context of a household or community, and thus gains important insights into everyday life.

#### **5.1.6 Focus Groups**

Informal interviews with small groups of people have often been used by anthropologists. More recently, professionals in fields such as market research have adapted and refined the technique. Focus groups can help to check information with a large number of people and to obtain reactions to intended innovations (e.g health educational materials, the location of a clinic, the introduction of community health workers). They are not successful in eliciting information considered private or concerning behaviour that might be subject to disapproval since people usually are reluctant to share such information in a group setting (see also Section 6.0).

### **5.2 TYPES OF INFORMATION RECORDS**

For the anthropological work, the core of the research, three types of information records should be maintained.

#### **5.2.1 Brief Diary**

The anthropologist will note in a diary very generally (without detail) what he or she has done each day of the study (e.g. "July 6, 1983, A.M. Interview with Mrs. D in the Parkview Nursing Home in Santa Monica. Lunch in Hollywood. P.M. Interview with Mrs. C. in private home in Hollywood"). It should be understood that this diary is a chronographic record of the daily activities of the anthropologist. It is not the field notes.

#### **5.2.2 Brief Field Notes**

The anthropologist will also take brief notes of the observations and interviews that he or she conducts and will later amplify in detail. This amplification is also an activity that must be done daily, and time must be set aside specifically for the amplification of field notes.

Take *brief notes* during interviews except when you think that note-taking will inhibit the conversation (e.g., when an individual takes you aside and tells you something that he/she considers very confidential). The notes should include (in abbreviated form) the question and key words in the responses. Once in a while it is useful to note the exact words of the individual and write them in quotes: "I always take my medicine in the morning after breakfast". You also note what you observe using parentheses: "(She's telling me that she can't stand up steady too long and yet she has been standing straight since I came in an hour ago.)"

### 5.2.3 Expanded Field Notes

The *same day* expand on your brief notes. The key words in your notes should remind you of many phrases and ideas. While you are expanding on your notes add your impression in parentheses, e.g. "(I saw that she seemed very upset today because she only wanted to discuss the illness of her neighbour. She did not want to sit down and she was twisting her hands constantly.)" Read over carefully what you have written. You can add details on the same page or you can add them on an additional page with numbered inserts.

Note questions that occur to you as you go over your notes daily. In addition to noting these questions in the report, put them in your notebook so that you have them ready when you return to that house e.g. "I still need to ask her why she thinks not eating breakfast makes her forget what she did the day before."

Consider the pros and cons of tape recorders very carefully, remembering that you will have to interpret or transcribe everything you record. Be sure that tape recordings do not inhibit the conversation, and do not avoid taking brief notes. It is best to use a tape recording only to aid you in expanding on your notes.

## 5.3 FILE ORGANIZATION

You must make a few copies of your expanded field notes, to be distributed as follows:

- for the research co-ordinator (principal investigator);
- for the field worker;
- to be filed by theme (you may need more than one copy as the same conversation may touch several themes);
- to be filed by family.
- to be filed by institution (nursing home or geriatric centre)

Your field notes can also be cut up into portions that cover various themes and these portions filed in the appropriate folders. The folders to be maintained by theme include the following:

- the community or institution (general description),

- socio-economic factors in the community,
- health resources (description of resources within the community and accessible outside the community, both in the Western biomedical system and the endogenous medical system)
- definitions of health and illness, beliefs
- illnesses and possible solutions, remedies, healing rituals
- general (ideal) diet for older people with problem X
- attitudes about old age, retirement, physical impairment, mental health
- ways of coping with loneliness
- utilization of health resources
- personal experience with health services and representatives of health resources and services.

### **5.3.1 Family file**

There will also be a folder for each family in the study, if the older person interviewed lives with his/her family. In this folder you will file the family composition sheet, the questionnaires on the household and other socio-economic indications for that family, and each of the interview or data collection guides to be completed for that family. The guides are filled by taking brief notes during conversations, informal interviews, and observations in the field and then amplifying on those notes in the appropriate guides. If space on the guide sheet itself is insufficient, you can use additional sheets to expand on themes using numbers to indicate where that additional information would fit on the guide sheet.

The family folders will also contain other field notes based on observation or conversations with that particular family. Finally, you should make a copy of each guide completed for each family in order to send it to the research co-ordinator.

The data collection guides are to help guide the interviews and to standardize the information that is collected in different countries on the family study. They should not be used as questionnaires. In each informal interview or conversation it is possible to discuss in detail one or more themes in the guides, and a series of informal interviews and conversations supplemented by observation will be used to fill in the guide. The specific guide might not be completely filled in one or even two interviews. Informal interviews and conversations should be conducted with both the older people and with the people they live with.

### **5.3.2 Nursing Home/Geriatric Health Centre Files**

For those older people interviewed living in a geriatric care facility, a file will be kept on the institution and individuals' experience there, including comments of health care personnel and professionals, patients, visitors, media. Observations of the physical environments, and services offered might also be noted.

## 5.4 INTERVIEW AND CONVERSATION TECHNIQUES

Some suggestions and examples to assist in the ethnographic work are as follows:

1. When the specific person, usually the older person that you are looking for is not there, chat anyway with other members of the family or neighbours. Sometimes information emerges that the person you were seeking would not have told you.

*Example:*

A researcher did not realize that the daughter of Tomasa lived with her until she found her in the house one day when Tomasa was not at home. The conversation with the daughter that day yielded some very useful information. In addition, these conversations can help you cross-check information that you have gotten from other individuals.

2. You must respect the confidentiality of the interview. You must be very careful not to make comments about one person you are studying to the neighbours, or to others in a nursing facility.

*Example:*

A neighbour: "Good-morning Marielle, how is Mrs. Golding? Could it be true what they say that her husband left her for another woman?"

Marielle: "Well I don't know how that is, Joan. And your son-in-law, how is he?"

Another aspect of confidentiality is to use first names or initials in your field notes but to use only pseudonyms in the final report. The actual names and addresses of the families studied should be kept in a safe place. The specific name of the community studied can be replaced by a pseudonym in the final report at the researcher's discretion.

3. Don't influence (bias) responses.

*Example:*

Question: "Why is it best that a person with diabetes not eat sugar?" This question biases the response because you are already suggesting that the proper treatment for diabetes is reducing sugar intake. The same question could be asked without introducing as much bias by asking, "Why are you eating a sugar-free diet?"

Answer: "Because it is good for diabetes." Question: "Why is it good?" Another alternative would be to ask, "What do you think about eating sugar?"

4. Don't influence (bias) with your attitudes and behaviour.

*Example:*

"Well, Mrs. Silver, I see that you always take your medication, that's very important

you know." This tells Mrs. Silver that you place a high value on medication compliance. This may bias the study. Alternate: "Mrs. Silver, how much medication do you take?" or "When do you take your medication?"

5. Try to work in as much depth as possible. Avoid being satisfied with superficial answers or moving too quickly from one topic to the other. Work for detailed responses. Use phrases like: Why? How did you feel when that happened? Did you see that? Did you do that? What do you think or what did you think? What happened when?

*Example:*

"I spent all day yesterday at the Health Centre." Question: "Why do you think that happened?" (Listen for the response.) "How did you feel about spending the day there?" The probing questions should be neutral; that is to say, they should not influence the responses. Don't change the subject too abruptly and try not to interrupt your informant.

6. When you want to be sure that you have heard clearly what the informant was saying or that the informant really intended to say what you heard, you can avoid the necessity of repeating the question with the tactic of reflecting back the response.

*Example:*

Question: "What do you think caused your cataracts?" Answer: "Reading in poor light when I was younger. Question: "Oh, reading in poor light caused your cataracts?" Answer: "Yes, you know lack of light puts a strain on the eyes and makes them more prone to problems."

This technique can also be used when the informant asks a question. You can reflect the question back.

*Example:*

Informant: "Is it true that aluminium consumption causes Alzheimer's disease?"  
Response: "What do you think? What have you heard?"

7. The previous example also illustrates a form of postponing answers to questions that are asked of you during the interview. If you give your opinion, you will not then know what the informant thinks on the topic because you will have influenced the response. In the same way you should postpone the behaviour which may interfere with the study.

*Example:*

Taking an older person who lives with his/her extended family into a health care facility. You should only do something like that in cases where the elder appears to be in danger of death and only after having discovered what the family would do without

your influence.

8. Be patient. It is not necessary to be asking and talking constantly. Sometimes you can pause to think, and you can pause to let your informant think. If you wait, sometimes your informant will feel more comfortable and will elaborate on a point.
9. Don't interrupt the work of your informant. Your informant is doing you a favour by participating in the research. If she (for example) asks to interrupt the conversation to talk to a nurse if she lives in a nursing home, or to talk with her children/grandchildren, or other people, or do work, tell her to continue her work with confidence. You can take advantage of this time to think, to look at your notes to see what else you would like to discuss, and to observe various aspects of the nursing home or household - how she interacts with health care staff and other patients, or with her spouse, children and other family members.
10. Always note the hour when you initiate the interview and the hour when you finish, who went with you, who was in the house or room during the interview, and who your main informant(s) was (were).
11. Be familiar with your instruments (data collection guides), both in terms of the general themes as well as some specific questions you have in mind under each theme. This will facilitate the informal interviews sounding like natural conversations. In addition, this will help you avoid asking questions that are irrelevant to the central focus of the study.
12. Don't make false promises or give false ideas of the study in order to obtain the co-operation of the individual selected.

*Example:*

"They are going to build a health centre here specifically for older people and that's why I want to know what you think of...." This would bias the study and complicate things for any future research or programme.

13. Always be truthful about your presence in the community, the purposes of the study, etc., in a manner understandable to your informants: "I want to know about illnesses of older people here and how they are treated." Your relationship with informants and other people in the community should also be accompanied by the truth.

*Example:*

The informant asks you: "What are you writing?" You answer: "What you are telling me, because I am very interested in this remedy." (You should be able to show your informant what you have been writing. When you wish to make notes you think might confuse the informant, it would be best to jot down a few key words and elaborate on

them later.

14. For your interviews use a moderate tone of voice, not too loud, not too soft; be natural. If the elderly subject/informant is hard of hearing, then pitch your tone of voice to be heard. Do not ask the questions in an imperative tone as this can inhibit or bother the informant. Remember that he or she is doing you a favour by participating in the study. Conversations should be in friendly respectful tones. The interviewer should use the local language and be very familiar with local customs.

## 5.5 OBSERVATION TECHNIQUES

In the context of ethnographic work, *observe* means to examine with all of your senses an object, one or several people, a social event, etc., with the objective of describing it. In this study the anthropologist will make general observations on the community, the health resources, and the older people being studied.

As indicated above, the brief notes based on your observations will be expanded in your field notes, and observations noted during the interviews will be put in parentheses. In making observations during a visit to an older person, you should try to:

- compare what the informant does with what he/she says; - see how the elder (or person in charge) prepares and combines food, note quantities of food in the house, etc.;
- see how the older person relates to other household members or other personnel and patients at a geriatric facility - watch for signs of attention, affection, rejection. etc.;
- observe when and how much medication the patient takes.
- observe what the person eats, how much, etc.
- observe the relationship between the older person and his/her relatives, or caretakers particularly, look for who influences or makes decisions in relation to health-seeking behaviour;
- observe the general conditions of the household or institution

Observations of family members can include:

### 1. *Use of space:*

This refers to distances between people and how they position themselves in relation to each other. For example, an older person with a hearing disability may stand closer to others .

## *2. Use of body, positions and gestures:*

Posture and gestures of people communicate a great deal - calmness, agitation, impatience, anger, tension, boredom, interest, pain, etc. For example, a person who is not calm during the interview may sit or stand in a very closed manner with the arms close to the body, perhaps moving an arm, a leg or a hand repeatedly, twisting their hands, etc.

## *3. Tone of voice:*

By the same token, tone of voice reflects a great deal about a person's emotional state.

## *4. Touch:*

This includes touching between an older person and family members, peers. For example, note if the elder is touched more by one child or grandchild than another.

## *5. Eye-to-eye contact:*

For this study, between patient and health care personnel or older person and family members is very important. For example, if you are interviewing an older person and note that she is distracted from your discussion to look at her grandchild, especially eye-to-eye, this indicates attention and love being shared amongst the family members. On the other hand, an elder who never is looked at by others in the household during a long conversation may not receive much attention in the household. The meaning of things like tone of voice and eye-to-eye contact will vary from culture to culture, so be sure that your interpretations of the behaviours you are observing are culturally appropriate.

You should always note the condition of the older people you are interviewing. In particular look for signs of functional disability such as vision or hearing or changes in dress (e.g. patient usually wears simple dress, one day she is in bathrobe). Respect your impressions. If you note that the person has changed from visit to visit and you think the person's condition is worsening, note that (use parentheses to indicate the distinction between your impression and what a relative might be telling you).

You should always observe as much as possible eating and eating habits and steps that are taken to improve health or remedy an illness state in older people. A set of dirty dentures on the counter, or a preparation of a home remedy are examples of observations important for this research.

## **6. FOCUS GROUP METHODS**

## **6.1 SELECTION THE SAMPLES**

### **6.1.1 Communities/Geriatric Institutions**

The studies using the focus group technique for gathering information will be carried out in the communities or geriatric institutions chosen for the study in each country. No fewer than five group meetings will be carried out in the community/institution.

### **6.1.2 Participants**

In general, the meeting participants in the first phase of the study will be older people. Focus groups comprising 'young old' and 'old old' (see Section 2) may be desirable in order to deal with the issues relevant to these distinct age groups more effectively. The communities studied might possibly be homogeneous enough, otherwise, you should take into account the necessity of talking with representative elders of various subgroups (from low and high levels of education, ladinas and indigenous, for example). The rule, nevertheless, is that the participants should be homogeneous in their socio-economic, cultural and educational levels.

For studies of health resources, the participants in the meetings will be providers of some type of health service. For example, it's possible to organize meetings of personnel of the official geriatric health services centre in the community, of the rural health promoters, of the psychologists, nurses, the staff from pharmacies, etc. The group must always be homogeneous (separate meetings for pharmacists, psychologists, etc.)

## **6.2 METHOD OF FOCUS GROUP**

Focus groups or interviews are a qualitative research technique. A focus group meeting is a discussion in which a small number (6 to 12 people) of informants, guided by an facilitator or moderator, talk freely and spontaneously about themes that are considered important to the investigation. The participants are chosen from a 'focus group' whose opinions and ideas are of interest to the research. Usually more than one group session is needed to assure good coverage. The focus group's meeting usually is tape recorded, although there is also a secretary or recorder taking notes of the discussion.

Information is obtained through discussion. This consists of an open conversation in which each participant is able to speak, ask questions of other participants, and respond to the comments of others, including the facilitator. The interaction between the participants is stimulated by the discussion of various themes relevant to the research. The facilitator guides the sessions so that all of the subjects of interest are covered.

One session of a focus group typically lasts an hour and a half. Generally, the first sessions are longer than the following because all of the information is new. In the following sessions the

facilitator is able to move the discussion more quickly over the points that have been treated by the other groups, when and if she is sure that both have the same opinion.

The place where the focus group meeting is held should be one in which the participants feel comfortable talking openly, it should be a neutral place in terms of the interests of the investigation. For example, the health centre of the community is not an appropriate place to have meetings about local medical beliefs or the use of different health resources. The parish hall or the municipal hall would be more appropriate.

### **6.2.1 Invitation to Participate**

The investigator will visit the houses in the community or nursing care or geriatric institutions and will invite older people to participate in the focus group. While making the invitations it is worthwhile to follow the following steps:

1. Talk about something of interest to the potential participant, for example, about their neighbours, peers, children, the climate or the marketplace.
2. In a sincere way tell him/her about the institution you work for and the objectives of your visit to the community.
3. Explain about the meeting you wish to have with the other seniors of the community and invite him/her to participate in that meeting.
4. Indicate the date, time and place of the meeting and how long the meeting will last. It will encourage her to know that neighbours will be attending. Mention names of some of those who have volunteered. You may also mention that refreshments will be served.
5. If the elder states that he/she does not wish to participate, or cannot, then thank him/her and leave; noting the reason for refusal.
6. If the older person expresses interest in participating, repeat the day, hour, place and make a brief statement about the importance of his/her participation and of being punctual so that the others are not kept waiting. Transport may need to be arranged.

### **6.2.2 Before Beginning the Meeting**

The facilitator and the recorder should be the first ones to arrive punctually at the meeting place. They start talking informally with the participants as they arrive or with other curious individuals who may have gathered. You can take advantage of this time to and learn people's names and something of their interest. Generally, almost all will avoid being the 'first to arrive' and will wait until they see others arriving. Therefore, you should give the impression that all is ready to

begin.

The facilitator should insure that the seating arrangements of all participants will encourage them to talk. It is better that the participants sit in a circle, more or less the same distance from the facilitator. The facilitator should make sure that there are no interruptions from other persons, children or animals.

### **6.2.3 Characteristics of the Good Facilitator**

- a) The facilitator should have a neutral attitude during the meeting. The intonation of the questions should not suggest the answer. The tone of the voice should be friendly, but neutral, in order to encourage the comments of the participants. The facilitator with her gestures and other nonverbal communication should not seem to approve or disapprove of comments of the participants. For example, you must take care not to move your head in signal of approval or disapproval as a reaction to the comments of a participant. The facilitator should not express personal opinions that could influence those opinions of the participants. Avoid asking more questions of a person whose ideas agree with yours.
- b) The facilitator should know his own biases or prejudices to assure that these are not manifested verbally or non-verbally during the meeting.
- c) The facilitator should have a sense of humour.
- d) The facilitator should have a sincere interest in the people and in learning about them.
- e) The facilitator should have empathy and be able to understand not only what people are saying but what it means to them. For this reason, it may be important for the facilitator to be of mature years.
- f) The facilitator should be enthusiastic and lively.
- g) The facilitator should be able to express himself/herself well in order to formulate the questions and also to react suitably to the comments, remembering that this should be done in a neutral manner.
- h) The facilitator should be flexible and open to accept suggestions, changes, interruptions and negative participation.
- i) The facilitator should know how to listen in order to follow an efficient pattern for the meeting, relating participants' comments to the next question. For example: "Your point about how long you have to wait at the doctor's office reminds me that I wanted to ask where you go if you don't have time to go the doctor?".

- j) The facilitator should always observe the group and be conscious of their participation and reactions. For example, quiet people should be encouraged to speak.

#### **6.2.4 Tasks of the Facilitator**

- a) The facilitator should introduce the topics for discussion.
- b) The facilitator should direct the group and not let herself be directed by the group. His/Her direction should not be 'slanted' (towards what she wants to hear).
- c) The facilitator has to assure the participation of all and not just one or two that try to talk 'on behalf of the group'. For this you should use the group management techniques discussed previously.
- d) The facilitator has to change the initiator - interviewer relationship to a more egalitarian group discussion so that the participants will begin to communicate among themselves, forgetting the presence of the facilitator.
- e) The facilitator has to gain the confidence of the group.
- f) The facilitator has to see that the group understands and believes that she wants to hear negative opinions as well as positive ones. This can be easily done if the group believes that the program, materials, etc. do not 'belong' to the facilitator.
- g) The facilitator should control the time given to each question and to the meeting in general, without seeming to control the time and without seeming to rush the participants.
- h) The facilitator should control the rhythm of the meeting. For example, she should move the conversation quickly over issues that have been discussed by other groups, if she is sure that this group has the same opinion. On the other hand, she should discuss in depth new information or opinions that arise that have not been discussed in other groups. For this reason, the first focus group that is held in one place is always the longest.
- i) The facilitator has to direct the discussion towards the subject of interest. If the participants stray off the subject, they must be diplomatically guided back to the original subject.
- j) The facilitator should always be aware of the non-verbal communication of the participants. For example, the manner in which they are sitting or if their actions reinforce or deny what they are saying. The gestures and actions also show impatience, tranquillity, tiredness, boredom, nervousness, etc.

- k) The facilitator should always moderate the tone of his/her voice. If one uses an imperative tone to ask the questions it can intimidate the participants. In the probing questions, where the question is asked several times, it can seem that the participant is being attacked if a friendly voice is not used.

### **6.2.5 Introduction to a Focus Group Meeting**

The introduction to a meeting is a key moment because it determines the tone and the ambience. At the start, the facilitator should be animated and chatty so that the people are comfortable. The introduction should include the following:

- a) The facilitator should introduce herself and introduce the recorder by name and explain the role of both in the group.
- b) Then the facilitator should ask the first and last names of the participants. It is very important that the facilitator learn the names quickly and then use the names when speaking to the participants. It is likely that elderly people may prefer the dignity of being addressed as Mrs/Mr/Miss rather than the familiarity of first name.
- c) The facilitator should explain that they (the facilitator and the recorder) are not there to give an educational lecture, but to incorporate the group's ideas into an educational campaign.
- d) She should also explain that they are not experts on the subject, the meeting has been called to learn from the participants.
- e) The facilitator should explain that the opinions of all the participants are important and that she wants everyone to feel free to express their opinions on the subjects to be discussed.
- f) The facilitator should explain that the only rules of the meeting are that the speaker stick to the subject being discussed and that one person speak at a time.
- g) The facilitator can start the meeting by asking information not related to the subject of each of the participants so that all may have the opportunity to speak about a neutral subject at the beginning of the meeting. For example, (s)he can ask how many years they've lived in the village.

### **6.2.6 Management Techniques for a Focus Group**

There are some easy techniques to learn and apply in the management of a focus group. These are used over all in the formulation of the subjects or the specific questions that is hoped the group will discuss at the meeting.

#### 6.2.6.1 *Clarification (or tactics to reveal the answer)*

After the question has been answered by a participant, it is possible to repeat said question for the purpose of clarification or further discussion. For example, "Can you tell me more about...?" or "What do you mean when you say...?"

#### 6.2.6.2 *Substitution*

This is a change in the presentation of a question, using some different words and fitting to the local language, but without change in the original meaning of the same. The facilitator should be sure that the way that the question is formulated does not hint at the answer. For example: "How often do you clean your dentures?" "When do you soak your false teeth?"

#### 6.2.6.3 *Reorientation*

This technique helps liven up a discussion. Once a person has responded to a question, it is possible to take advantage of that and restate the question. For example:

"Mrs. Smith (participant) you tell us that you eat bran flakes and prunes for breakfast. And you, Mrs. Jones (another participant who has not given an opinion) "what do you eat for breakfast?"

#### 6.2.6.4 *The Problem of the Expert*

It is best the 'specialists' like the health promoter, the psychologists, the nurse or those with authority, like the mayor, not be present at these meetings, unless the focus group is scheduled specifically for them. Nevertheless, if they have to be there, explain to them, before the meeting, the best way for them to contribute is to listen to the discussion and then share their ideas and conclusions with the facilitator after the meeting.

#### 6.2.6.5 *Problem of the Dominant Participant*

When the group has a dominant participant, the facilitator must try to elicit more active participation from the rest of the group. She can also change the subject and avoid eye contact with the dominant participant in order to avoid encouraging the dominant participant to speak. If all else fails, the facilitator can politely request that the dominant participant allow the others to speak.

#### 6.2.6.6 *The Problem of the Non-Participant*

When the group has a weak participant, the facilitator should direct attention to the participant using the participant's name and openly asking the participant's opinion. The facilitator can make

more eye contact with the reluctant participant, making it more inviting for the participant to give her opinion. It is possible to ask her to speak in more detail about what another person has just said or to sum up what the group has said about a subject.

#### 6.2.6.7 *Maximum Participation*

An effective way to achieve maximum participation from the group in general is for the facilitator to write out on paper what she does not know about the subject and mention her lack of information and need for knowledge, to the group. They will feel good about being able to provide information and will recognize the value of their experiences.

#### 6.2.6.8 *Tasks of the Recorder*

The recorder should note the following:

- a) The name of the community/institution and a brief description of the same. Information that can influence the activities of the participants, for example, the distance of the community/institution from the next largest town or political unit.
- b) The place where the meeting is held and a brief description of the same. Information on how the place can affect the participants, for example, if it is adequate or not, if it is comfortable or not for the activities being undertaken.
- c) The number of participants and some characteristics of the same, for example, sex and approximate age.
- d) The time the meeting begins and ends.
- e) The dynamics of the group in general, the level of participation of the attendees. For example, note if one person dominates the group or if all participate equally, if they are tired or bored, etc.
- f) The interruptions and distractions that occur during the meeting.
- g) The questions that make the people laugh, what is done to end the discussion, or what seems to make the participants reluctant to answer.
- h) The opinions of the participants in phrases like this: the majority of the group is of the opinion that...but Mrs. Smith said...the group is divided in the middle, some think that...etc. She should use quotation marks to indicate the words of the participants. Her own impressions and observations should be noted in parenthesis. The recording of the meeting will help amplify her notes. (The recorder is responsible for the handling of the tape

recorder.)

- i) The general vocabulary of the participants. That is to say, the recorder should make an effort to record the participant's own words. You are trying to learn as many local expressions as possible to use in the design of educational materials.

#### 6.2.6.9 *Participation of the Recorder in the Discussion*

The recorder may participate in the discussion especially to:

- a) Listen to comments missed by the facilitator while listening to another person. In that case the recorder can say something like: Mrs. Smith mentioned something that we did not hear; could you repeat what you said, Mrs. Smith?
- b) If (s)he thinks of a new question or topic important to the study.
- c) Note that the facilitator has forgotten a question from the guide. (Both the facilitator and the recorder should have a copy of the guide questions at the meetings).
- d) Note that the facilitator has lost control of the meeting.
- e) If (s)he thinks of a way to make the discussion more meaningful.
- f) (S)he can help the facilitator resolve internal conflicts. Nevertheless, the recorder should remember that it is the facilitator who directs the discussion and comments made during the meeting. The recorder may help the facilitator in the manner discussed above, but without undermining his/her authority.

#### 6.2.7 **Ending the Focus Group Meeting**

The closure of the focus group meeting is an opportunity to:

- a) Obtain new information. The facilitator should explain that the meeting has ended, ask the participants to think about what has been discussed and ask them one by one if they have any other comments. Afterwards pursue the comments in greater depth.
- b) Thank the participants for their contributions and restate to them that their ideas will serve to design educational materials that (s)he hopes will be useful to the community/institution and others like it.

### 7. **SELECTION, TRAINING AND SUPERVISION OF FIELD WORKERS**

Ideally, in anthropological research all data are to be collected personally by the anthropologist. This involves continuous long-term contact with one single community that is not always possible due to limitations of the researcher's time and other responsibilities such as teaching, administration and other research duties. In such a situation, the assistance of field workers becomes necessary. Since anthropological data collection requires learning the art of field - work using limited instruments, careful attention should be paid to the selection, training and supervision of field workers involved in data collection.

## 7.1 SELECTION

- a) The field workers should preferably have a master's degree in the field of anthropology or a related social science. In situations where it is difficult to get master's degree holders, individuals with a bachelor's degree with previous community field work experience may be sufficient. For work in the elderly it may be more important to chose field workers of mature age and same ethnic background rather than young graduates.
- b) Previous experience in doing field work in ethnic communities should be an important criterion for selection. Willingness to live in or near the field site is a necessary prerequisite.
- c) Field workers should not have any formal affiliation or responsibilities with the major health services at the time of the study. (eg. a nurse providing health services may not obtain an accurate evaluation from her client population.)
- d) Field workers can be either male or female. Depending on the community to be studied, it may be necessary to have both male and female field workers, working together in pairs. The sex of the field worker is not as important as his or her ability to gain access to the older person to be interviewed, and accurately collect and record the data.

## 7.2 TRAINING

The selected field workers need to go through a period of training whether they have had previous anthropological research experience or not. The amount of time devoted to training will be determined by previous experience and familiarity in using ethnographic techniques. It is felt that no training should last for less than a week. It should involve both classroom lecture - discussion and field-work sessions.

- a) At the very onset the researcher should devote time to familiarizing the field workers with the subject and the goal of the research project. It is very important that the field workers understand the underlying meaning for collecting a particular type of data; otherwise, the quality of the data will be poor. Following the introduction and discussion of the research proposal, the researcher should explain the guidelines for data collection of elders living in

households and institutions. Each item in the guidelines needs to be explained clearly, and ethnographic techniques to be used will be explained in relation to specific items in the guidelines. For example, to gather information on how illness is managed, informal open-ended interviewing can be supplemented with case studies of particular illness in the older person. Also, the field workers need to know that, in order to get information on beliefs about health and disease, one has to start with careful observation of a particular type of behaviour and later ask the respondent why he/she acted the way she did. Field workers need to know how different ethnographic techniques can be used to gather information on different items of the guidelines. Both role playing and learning through participant activities can be helpful.

- b) No amount of classroom discussion can do the job of actual field exercise. The field exercise can be carried out at the research site or any other similar area. The procedure to follow is to have the field workers observe the anthropologist conduct field investigations. This should give field workers the necessary cues about gaining entry to a household or institution, what is needed in establishing rapport, and how to introduce themselves to the community/geriatric centre. The anthropologist should show them how to conduct an informal interview and make field workers aware of the items and activities they are to observe. Following such a demonstration, the field workers will be asked to do a field investigation in another household/institution and write up the field notes after returning from the field. The anthropologist should discuss the field notes with each individual worker and point out both the strengths and weaknesses. The initial field exercise can be general, but later the field demonstration and exercise should be carried out with the specific focus of the research project.

The field workers will be asked to keep a field diary for notes taken in field. It is important for them to recognize that if they concentrate on writing detailed notes while in the household/institution, they are likely to miss important events, activities, and instructions and, in some cases, might even offend the informant. They should also be informed that under no circumstances should they disturb the elder's daily routine. The field worker has to accommodate himself to the informant's routine, and this is to be clearly understood by the field worker.

### **7.3 SUPERVISION**

Supervision should be a continuous process; otherwise the quality of the data collected will suffer. The procedure for supervision is as follows:

- periodic observation of the field worker in the field;
- review of field notes weekly to identify areas needing elaboration;
- frequent checks to determine whether any field procedure needs modification, and identification of areas needing attention of the researcher, e.g., if any assistance is needed in getting continuous co-operation of the individuals, households and institutions.

Supervision is needed not only to check on the quality of the data but also to give the moral support and confidence to the field workers essential for their effective performance.

## **8. DATA ANALYSIS**

### **8.1 INITIAL ANALYSIS**

The process of analyzing data includes the careful revision of all information collected from the community study and household case studies. The following procedures and techniques will be found useful in data analysis.

#### **8.1.1 Mechanics of Organizing the Data**

The first activity is to organize the information as follows:

- a) Files for each of the communities in the study. Include all available data, whatever the source.
- b) Files for each of the households in each community. Description and characteristics of each household from chance observations as well as use of the instruments. Files for each of the health resources in the study. Description and characteristics of each resource from chance observations as well as the use of the instruments.
- c) Files for individual research topics. One folder must be prepared for each research topic according to the guidelines for data collection, i.e definition of health and illness, common illness and solutions, treatment at health resources, etc.

In order to organize these files, the case studies of each household should be broken down into sections using headings (taking common aspects of health and illness from all cases and putting them together). Be sure to use the family identification numbers to distinguish cases and communities. When health resources are studied as well, similar groupings should be used (e.g. waiting times, staff-patient interaction). Each health resource should have its own identification number.

### **8.2 INTERIM ANALYSIS**

Much of the data obtained from this guide will be in words rather than in numbers. The data analysis is not something to be done only after all data have been collected, but is part of a continual process of examining the information as it is coming in, classifying it, and generating further questions or attempts to verify existing information and developing conclusions. Miles and Huberman (1984) have provided an extensive and useful discussion of this process, portions

of which are included in the following discussion.

### **8.2.1 Additional categories**

The data collected may generate the need for additional categories. This may include additional data collection guides or additional topic files. For example, the application of an earlier version of this manual to research on epilepsy revealed that the events which occur between the first suspicion that something is wrong and an accurate diagnosis and successful treatment are often so many and complex in the case of epilepsy that a separate data collection guide had to be developed just to deal with the search for a diagnosis. Similarly, so much information emerged from various guides on what epileptics and their families wished other people knew about epilepsy that a separate topic file was developed for this information. Both the guides and topic files must be fluid and sub-divide or merge according to the needs of the project and the dictates of the data.

### **8.2.2 Memoing**

'Memoing' (Miles and Huberman, 1984) is a brief conceptual examination of some aspect of the data. For example, we were asked to look at information on diarrhoeal disease after the initial investigation which led to the development of this manual. The data which emerged from our rapid summary was used to develop a major research project and led to our expansion of the data collection guides on this subject (Scrimshaw and Hurtado, 1985).

### **8.2.3 Researcher meetings**

If more than one field worker is involved in one or more sites it is important to meet periodically and discuss main themes, emerging hypotheses, alternative explanations, disagreements, next steps for data collection and any revisions to the data collection guides (Miles and Huberman, 1984:25).

### **8.2.4 Periodic review of the files**

The household, the health care provider and the topic files must be periodically reviewed for degree of completion, work remaining to be done or refined and quality (reliability and validity) of the data.

### **8.2.5 Analytical Dimensions**

As soon as the data are collected, proceed to describe the communities, considering all its characteristics, then proceed to review the data from the household. Describe the data of the household with: sex, parity, age, occupation, physical conditions of the household, family composition, and structure. (The cases and communities should have code numbers for

identification.) Descriptions should also be generated for each type of health resource.

### 8.3 MAIN DATA ANALYSIS

#### 8.3.1 Descriptive Figures

A variety of descriptive figures can be extremely useful for this type of data.

##### 8.3.1.1 Organizational charts

These show the relationships between staff at agencies (see Table A2.3)

**Table A2.3 Health resources in a rural village.**

Health post
Fifth year medical student
Auxiliary nurse
Community Health Worker

##### 8.3.1.2 Flow Charts

These can be used to describe and even contrast a flow of events. In a study of elderly in the town of Spata, Greece, inappropriate use of prescribed medications was found to exist. Medications were often taken by some elderly participants, only when they believed they should be taken. One elderly lady was found to take her medication for hypertension only when meat was eaten. Flow charts could have been used to contrast the woman's beliefs as opposed to the actual expected pattern of events. These charts helped medical staff understand why some elderly are not adherent to medication prescription.

A variant of this is an event-state flow chart (Miles and Huberman, 1984), which can be better illustrated with another example from the Greek elderly study, in cases where elderly were suffering from diabetes and were on oral medication or insulin. Many had the belief that carbohydrate foods should be totally omitted from the diet in order to achieve control of their diabetes. An event-state flow chart can be used to compare and contrast elderly expectations or beliefs of their role or 'job' in helping to treat their disorder and what is actually expected of them (see Table A2.4 and Figure A2.1)

**Table A2.4. Expected behaviour of elderly diabetic patient by medical practitioner.**

diagnosis of diabetes	→	carbohydrate foods distributed	→	prescription of oral
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across day

medicine  
or insulin

**Figure A2.1.** Actual behaviour of elderly diabetic patient.

8.3.1.3 *Weight charts and Proneness to Infections charts*

The increase or decrease over time of some important variable which was quantified can be shown (Miles and Huberman, 1984) (see Table A2.5).

**Table A2.5. Use of Meals on Wheels Services.**

Number of elderly receiving meals on wheels
Number of weeks/months receiving meals on wheels

8.3.1.4 *Causal networks*

While great caution must be exercised in making causal statements, sometimes it is possible to describe deterministic relationships between independent and dependent relationships in a study (Figure A2.2)

**Figure A2.2.** Causal network for reduced body mass index and immune function.

#### 8.3.1.5 *Taxonomies*

An extremely useful analytic approach for ethnographic data is that proposed by Spradley in his two field guides (1979 and 1980). This involves analysis of the content of information gathered into cultural themes or domains. These can then be presented in the form of taxonomies, which help to organize and interpret the findings. Examples and give illustrations for diarrhoea. Example shows the way people in one community, in general, describe types emanating from different causes, with variations in symptoms and appropriate treatment. Example classifies the possible treatments (Spradley 1979, 1980)

### **8.3.2 Descriptive Matrices**

#### 8.3.2.1 *Cross-tabulation*

Complex statistical analysis will not be feasible with the limited and primarily qualitative information to be collected. Nevertheless, simple statistical tabulations will be required to describe some of the salient characteristics of the household or health resource and individual patterns of the beliefs, knowledge and Behaviour of the individual families and health care providers. Miles and Huberman (1984) refer to tables like these as descriptive matrices and suggest that they can be extremely useful to 'eyeball' data. They can include time periods, persons, groups, roles, event classes, settings, processes, key variables, and so on.

For example, cross-tabulation may be used to describe the attitudes regarding health services of families of differing socio-economic status. Suppose the researcher or researchers classified individual families into three groups on socio- economic status - low (L), middle (M), and high (H) - and attitudes towards health services into three groups also - negative (N) mixed (M) and positive (P) (see Table A2.6).

**Table A2.6. Sample cross-tabulation of data on family socio-economic status and attitudes toward health services.**

Elderly health status	Family socio-economic status			Totals
	L	M	H	
N	2	0	0	2
M	2	6	2	10
P	1	4	3	8
<b>Totals</b>	5	10	5	20

If the data justify it, chi-square test of significance may be applied to such a distribution. However, it should be explicitly noted that this test cannot be used appropriately when the sample size is very small or when the distribution is a variable dependent on the selections. Unless the families have been randomly selected, data based on them cannot be interpreted as representative of the whole community.

#### 8.3.2.2 Checklist

This reports on a listing of items, events etc. which were elicited in the data collection. For example, the data summary on the inventory of medicines in the home would yield a list of items commonly found in the homes studied, with perhaps a distinction between those found in all homes, those found in some homes, and those found only once or twice.

#### 8.3.2.3 Time-ordered list

An example of this would be a report on an observation of time use (see Table A2.7).

**Table A2.7 Observation of time use in an elderly Aboriginal community.**

	Grandmother	Grandfather	Child	Grandchild
6 AM	makes damper	makes tea in billy can	asleep	asleep
6.30 AM		sits around goanna hunting	prepares to go	asleep asleep
7 AM	camp fire sits around camp fire	located a truck to take to bush	dressings	dressings
11AM	makes damper	cooks goanna on camp fire	shopping	grandfather shows shows grandson how to cook goanna

#### 8.3.2.4 Role-Ordered listing

Role-ordered listing would 'distribute data according to sources or targets of attention' (Miles and Huberman 1984) (Table A2.7).

<b>Table A2.7. Medical Clinic Staff Roles</b>	
<b>Clerk</b>	Records name, assigns number, asks patients to wait
<b>Nurse</b>	Weighs patient, records height, takes blood pressure, asks for urine sample, takes blood sample
<b>General medical practitioner</b>	Performs general health examination

#### 8.3.2.5 *Conceptually clustered variables*

This brings together variables which seem to be associated. For example, in the study of elderly Greeks, we noted that anxiety was associated with blood testing. It would be possible to pull together a set of conceptually clustered variables which included anxiety about the procedure of drawing blood (e.g. pain associated with venepuncture, amount of blood being drawn) and concern that undesirable findings would be obtained. This would have implications for health care programmes for the regular sampling of blood and could help explain survey response rates.

### 8.3.3 Conclusion Drawing

The total 'data set' will be difficult for most people to read or understand. Rather than exhaustive listing of detail, a report must make generalizations and provide specific examples drawn from the material which provides the basis for generalization. In effect, many of the analysis techniques already described represent forms of generalizing. The researcher must also be prepared to make statements like in the study of elderly in the town of Spata in Greece: "In general, the grandparents in the household are consulted with regards to traditional herbal remedies".

In order to reach generalizations, look for differences and similarities according to the analytical dimensions (report outline) for your research. Try to identify what is salient. Each difference must be explored deeply (e.g., why one individual exhibits one Behaviour such as going to the clinic, and another does not). The data should be analysed in such a way as to highlight findings relevant to the purpose of the study.

Data may be examined in the following ways in order to develop generalizations:

#### 1. **Counting**

For example, number of people in households, hours spent grinding corn, hours spend in the fields, number of community health workers in the village.

## **2. Noting themes**

Anxiety associated with blood drawing is a theme, as is the use of the Greek elderly as providers of advice about traditional medicine

## **3. Questioning plausibility**

Health officials in one country told us that there were no traditional medicines used, only modern. This did not seem plausible, and an examination of the data showed that traditional medicines were indeed being used.

## **4. Relations between variables and finding intervening variables**

For example, the type of health care provider sought has been shown to be a function of the perceived severity of the illness, the perceived efficacy of the cure and cost (time, money, dignity, etc.) of the treatment (Young, 1981). The availability of the treatment might be an intervening variable in case like this.

## **5. Building a logical chain of evidence**

Generalizations and conclusions must be supported by building a chain of evidence and by conceptual and theoretical coherence (Miles and Huberman, 1984). For example, in Spata Greece, there are strongly held beliefs amongst elderly folk about the use of bread, olives, olive oil and wine as health giving foods or beverage. There is however an apparent problem of hypertension amongst these same people. Current evidence links sodium intake and ethanol ingestion to the pathogenesis of hypertension. There is, therefore, a traditional logic linking overall food patterns to health, and a contemporary medical scientific logic, which links specific nutrients (sodium and ethanol) to a clinical finding - namely hypertension. The logical reconciliation of these to health constructs may be to restrict the medical scientific view to those who exhibit the hypertension and to accommodate the traditional view for the community at large. This should then minimise barriers to management of hypertension whilst not being unduly interfering about traditional health beliefs and values.

### **8.3.4 Reliability**

It is important that the data support the conclusions and that another researcher working at the same site would come up with similar findings. Miles and Huberman(1984:27) strongly urge that the researcher check for representativeness by:

1. Increasing the number of cases.
2. Looking purposively for contrasting cases (cases which look different from the others).
3. Ensuring that all cases are developed to the fullest possible detail and to relatively the same degree of detail.
4. Sampling randomly within the universe, or, if that is not possible, ensuring that the sample includes the appropriate variability (e.g don't only talk to the friendliest people in the community, their quieter neighbours are just as important to the research).
5. Checking for researcher effects: In the Greek study, the researchers were often asked to share a meal with elderly couples. The foods shared on these occasions were often especially cooked for the benefit of the researcher, but in most cases did not represent what the elderly couple usually ate.
6. Noting researcher bias: Many things about the researcher such as age, sex, ethnicity and various personality characteristics will influence what the researcher is told or allowed to see and how he or she perceives events and people (Pelto and Pelto, 1978). This is particularly relevant when questioning elderly men and women since they may have entrenched intolerances. In the Greek study, a very shy researcher may underestimate the problems of urinary and faecal incontinence and the importance of sexuality. A less inhibited researcher on the team had a different view about these issues. It is very important for each field worker to be aware of his or her interests, perspectives and biases.
7. Triangulating across data sources means checking something from various perspectives. What someone says they do can be confirmed or not by observing the event or situation in question and perhaps also by hearing about it from a third party. In the elderly Aboriginal study we found elderly people saying that they ate certain foods regularly. However, cross checking by a) observing b) interviewing the cashier at the local supermarket c) interviewing the community health nurse demonstrated otherwise.
8. Weighting the evidence means deciding on the degree of reliability of information. There may be evidence that one source of information is extremely trustworthy while another is not. Also, one type of information may be more reliable than another. In Ecuador, the social desirability of having a latrine led to over-reporting. Observation of what people really had in a sub-sample led to the conclusion that information on latrines was unreliable (Scrimshaw, 1974).

## 9. FINAL REPORT

Each researcher should prepare a final report according to the following general outline.

## **I. Introduction and Statement of Purpose**

- A. General discussion of research purpose(s).
- B. Importance of older people's perceptions of geriatric health care.

## **II. Background National and Regional Information**

- A. Summary of available data on geriatric health care for nation and region/province; history of programme(s), etc.
- B. Reference to relevant studies.

## **III. Description of Study Communities/Geriatric Institutions**

- A. Reasons for specific community/institution selection (use pseudonyms if preferred; be brief).
- B. General data.

*For the Community* -if informant lives independently or with extended family:

- 1. Geographic/ecological setting
- 2. Demographic data/ethnicity
- 3. Communications (roads, etc.)
- 4. Socio-economic data (occupations, markets, etc.)
- 5. Educational facilities and attendance, general literacy rates, etc.
- 6. Water and sanitation facilities
- 7. Area map with study sites

*For the institution* if informant lives in nursing home or geriatric care centre:

- 1. Location in city/community
- 2. Demographic data/ethnicity
- 3. Socio-economic data (cost of stay, previous occupations of residents)
- 4. Size-(number of nurses, medical personnel, beds, residents)
- 5. Sanitation (cleanliness of facility)
- 6. Types of services/programmes available (recreation, medical)
- C. Health resources

*Endogenous*

- 1. Types and number of practitioners and facilities available (local and nearby)
- 2. Basic role of practitioners
- 3. Basic tenets of endogenous health care delivery system
- 4. Literature review, if available

*Modern*

- 1. Types and number of practitioners/facilities available (local and nearby)

2. Basic role of practitioners
3. History of geriatric health care in specific communities
4. Literature review, if available

#### **IV. Methodology**

- A. Sample selection of individuals in community(ies)/institutions
- B. Timetable of research
- C. Characteristics of researchers (sex, age, education, etc.); training and standardization of research techniques; supervision; participation in data analysis and write-up
- D. Techniques and instruments utilized (include contact time with older people, any optional statistical methods, etc.)
- E. Obstacles and problems, constraints (logistical, political, etc.)

#### **V. Results**

*Note:* Make comparisons between communities/institutions if relevant; present factual data in this section with ample use of case study examples as illustration.)

- A. Description of households/institutions and relevant individuals
- B. Beliefs about health and illness (common illnesses and possible solutions)
- C. Diets of sick elderly
- D. Health-seeking behaviour/decision-making
  - i. older women
  - ii. older men
- E. Knowledge and utilization of geriatric health care  
*Note:* Where applicable, relevant data should be gathered about geriatric health care personnel.
- F. Other aspects of health-related subjects (menopause, dental care) Note: Respondents should be women and men from the households/institutions.

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