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A naturalistic inquiry on the impact of interventions aiming to improve health and the quality of life in the community

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Abstract

The goal of this study is to identify and describe variables contributing to the efficiency of health promotion interventions, and to assess whether these variables can serve as reliable and early indicators of the success of such interventions. The study sample includes 44 interventions selected through a network of key informants from five cities—Liverpool, Sandwell, Vienna, Pula, and Rijeka—by using a chain technique. Data on each intervention are collected through an in-depth interview with a program leader, the collection of project-related documents, and on-site observation. Qualitative analysis of data performed with content analysis and computer-assisted free-text analysis reveals different characteristics of interventions depending on whether they are initiated by the city government sector, health-care system, or citizens sector (independent of the city or country). The assessment of the efficiency of these three groups of interventions also differs because of varying features, scope (activity potentials) and impact they are able to accomplish. We have identified ways in which the efficiency of all three groups of interventions can be improved. The efficiency of the interventions within the city sector can be increased through an improved process of delegation to other sectors, higher involvement of user groups, and higher receptivity and organizational flexibility. The efficiency of the interventions within the citizens sector can be improved through professional, organizational, and financial support. Support from the professional community is important for citizens sector interventions in confirming the importance of the problem they address and legitimizing the actions they propose and undertake.

Keywords: Community; Health promotion research; Impact assessment; Program evaluation; Qualitative methods

Introduction

There is no standardized method for evaluation of the impact of a health promotion intervention on an entire community. Most health promotion initiatives conducted in the last 30 years have used community-based approaches only to modify individual health behavior. Initiatives such as North Karelia (Puska et al., 1985), Pawtucket Heart Health Program (Assaf, Bonspach, Lasater, McKinlay, & Carleton, 1987), Stanford—Five City Project (Farquhar et al., 1990; Fortmann et al., 1995), Minnesota Heart Health Program (Mittelmark et al., 1986; Weisbrod, Purie, & Bracht, 1992), Heartbeat Wales (Nutbeam, Smith, Murphy, & Catford, 1993), or the Community Intervention Trials for Smoking Cessation—COMMIT (Green et al., 1995; Koepsell et al., 1992) aimed at reducing risk factors for cardiovascular diseases, (e.g., smoking, unhealthy diet, and insufficient physical activity). The studies evaluating the impact of interventions focused on measuring changes in health behavior and attitudes of individuals (e.g., cigarette smoking cessation rate), whereas the impact on the

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wider social environment and people or organizations carrying out the initiative (Hawe, 1994; McKinlay, 1992) was not examined. Thus, other possible benefits of these interventions were left unrecognized (Thompson & Kinne, 1990).

As health promotion interventions are costly, time consuming and require substantial efforts, it would be useful to have a method for a rapid assessment of their impact. Therefore, we decided to perform a qualitative research study to identify and describe variables contributing to the efficiency of health promotion interventions, and to assess whether these variables could serve as reliable and early indicators of success.

Material and methods

Our research design was based on Lincoln and Guba's naturalistic inquiry methodology (Patton, 1987, 1990; Lincoln, 1992). We decided to use a phenomenological (naturalistic) approach because it is especially suitable for describing, analyzing and understanding health promotion intervention in the context of social environment (Harris, 1992; Eakin & Maclean, 1992). Also, this approach allowed us to use evaluations of previously performed health promotion interventions and to identify retrospectively the characteristics of those that were successful.

To increase the strength and rigor of our qualitative investigation, we used three types of triangulation (Stecher & Davis, 1987; Patton, 1990, 1999; Peck & Secker, 1999; Lincoln, 1992): data (high-variability sampling), methodological (semi-structured questionnaires, interviews, observation, and document analysis), and investigator (several investigators from Croatia and UK).

Sample

The sample consisted of 44 health promotion interventions carried out in five European cities which participated in the Healthy Cities Project: Liverpool (UK), Sandwell (UK), Vienna (Austria), Pula (Croatia), and Rijeka (Croatia). These cities were selected by high-variability sampling (Patton, 1990) to ensure differences in population size (from Vienna, with over 1.6 million inhabitants, to Pula, with less than 50 000 residents), geographic location, standard of living, culture, tradition, and political orientation at the local and national level.

The health promotion interventions were selected by chain sampling (Patton, 1990) to avoid a possible investigator selection bias. In each city, we contacted 25–30 key informants who were all community residents in a position to know the community well, e.g., political leaders and professionals from the field of public health, media, clergy, unions, and chamber of commerce. They were asked to choose five or more programs or projects, which, in their opinion, contributed the most to the improvement of health or quality of life in their city. The response rate of key informants was between 66% (Liverpool) and 84% (Rijeka) after two phone calls reminders. Each key informant listed 5–10 different programs or projects. Only the projects mentioned by more than two informants were included in the sample, which eventually consisted of 11 projects from Liverpool, five from the District of Sandwell, nine from Pula, nine from Vienna, and ten from Rijeka. These 44 projects were aimed at a particular target population (e.g. children and youth, women, elderly, or people with special social or health needs); at improving the health-care system, health policies, and prevention activities (e.g., drug use prevention); or at community development and urban environment (Table 1). The sampling technique and data collection methods applied were identical in all five cities.

Data collection

Data on programs or projects were collected from 1993 to 1998, through in-person interview with the project leaders after their consent, by review of the documents, and by on-site observation of the intervention.

All interviews were tape-recorded and conducted by the same interviewer (SS—principal investigator) using a semi-structured questionnaire. The questionnaire consisted of 11 items inquiring about project history (how and why it was initiated), project structure, financial sources, objectives and methods of their assessment, project management and decision-making, collaboration with other sectors and agencies, inequity reduction, health promotion and prevention activities, project visibility, and its wider applicability. In 38 cases, interview was conducted with a single person (program leader), and in six cases with a project team (2–4 persons). Each interview lasted approximately for 40 min and was transcribed to ensure the accuracy of the collected data and facilitate the analysis (Rose & Webb, 1998; Higgins, 1998).

For case study preparation, transcripts of the interviews were completed with the data from available project documentation and with the interviewer's observation notes.

Data analysis

Two methods of qualitative text analysis were applied: content analysis and computer-assisted free-text analysis.

Content analysis: To organize the textual data into meaningful and manageable categories, two types of text