

# QUALITATIVE EVALUATION OF A PILOT PUBLIC AWARENESS PROGRAMME ON THE PROSTATE AND ITS FUNCTION

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This report is a revised version of the report of January 2007, which has had some minor adjustments following the helpful comments from the peer reviewers.

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# QUALITATIVE EVALUATION OF THE PILOT PUBLIC AWARENESS PROGRAMME ON THE PROSTATE AND ITS FUNCTION

## **KEY HIGHLIGHTS OF THE CAMPAIGN**

- Materials were developed with target audiences and consequently well received in target groups
- 8987 leaflets, 995 drink mats and 500 posters were distributed during one month
- All materials were used up at community venues and more requested
- Community development approaches were successful in reaching men living in areas with health inequalities
- Men attending workplace presentation reported a behaviour change
- Enthusiastic intermediaries, acting as community educators in the community, were willing to distribute and promote the campaign
- Successful partnership was developed with local authority for health improvement initiatives

## **1. BACKGROUND TO THE PROGRAMME**

This section looks at the background to the campaign, the key messages developed, how the programme sought to address health inequalities and information about the quantitative evaluation.

The Prostate Cancer Advisory Group (PCAG), a Department of Health advisory committee chaired by Professor Mike Richards, the National Cancer Director, and made up of health practitioners, researchers, patients and prostate experts, commissioned ContinYou, a national health and learning charity<sup>1</sup>, to pilot a public awareness programme on the prostate and its function.

### **1.1 A consistent set of messages**

Prostate cancer is the most commonly diagnosed cancer in men in England and the second biggest cancer killer in men<sup>2</sup>. The PCAG recognised that raising public awareness of prostate cancer is one of the key challenges for the future, because the messages are more complicated than for many other cancers: not all prostate cancers are life threatening. To begin to address this, the PCAG developed a definitive set of key messages. These messages (appendix 1) have been agreed by 20 organisations so that information on prostate cancer is both consistent and accurate. The messages are now fed into existing communications vehicles, or used as stand alone messages in simple communications.

The challenge for the awareness raising campaign was to raise understanding in a balanced way so as not to cause alarm and panic. The PCAG and its members are

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<sup>1</sup> ContinYou works to develop innovative approaches to widening opportunities for health improvement, learning and community regeneration, tackling inequalities and building social inclusion.

<sup>2</sup> 'Making Progress on Prostate Cancer', Department of Health, November 2004

aware that there is ignorance among men about the prostate, its function and what can go wrong. The aim is to empower men to make choices and seek early advice, but guard against undue worry, particularly as there is no firm evidence that testing for the Prostate Specific Antigen (PSA) in men with no symptoms saves lives.

## **1.2 Addressing health inequalities**

The awareness raising also needed to consider inequalities in health so that any impact of the campaign did not contribute to widening the gap, but achieved the best outcomes for all. Incidence rates are higher in more affluent groups, partly due to higher PSA testing rates. However, men from deprived areas have poorer survival rates<sup>3</sup>. It is also known that the incidence of prostate cancer is twice as high in African Americans than White men, and lowest in Asian and Oriental men. In 2003 the Prostate Cancer Charity set up a three-year project to raise awareness of prostate cancer in African Caribbean community groups and promote access to health care services. More information is available at: <http://www.prostate-cancer.org.uk/what/acp.asp>

## **1.3 The Pilot Project**

The aim of the project was to pilot a public awareness programme on the prostate and its function. It was to present information on benign disease as well as cancer, in order to give a balanced view and not cause undue alarm.

The programme was to target men over 50. Within this cohort, particular attention was to be paid to:

- Men with a family history of prostate cancer
- Men of African origin
- Addressing health inequalities by targeting appropriate sub groups

The initiative was to take place in one primary care trust (PCT), which was likely to be a spearhead PCT, where deprivation is high.

The successful bidder was not required to evaluate the pilot. A separate evaluation contract was to be awarded by the PCAG. Two evaluations, a quantitative one and a qualitative one were finally commissioned.

## **1.4 Quantitative evaluation**

The Cancer Screening Evaluation Unit (CSEU) at the Institute for Cancer Research is carrying out a parallel quantitative evaluation to evaluate the effects on primary and secondary care services of the pilot campaign. The study aims to measure, in time periods before and after the campaign launch, the rates of GP requests to pathology laboratories for PSA measurements, the rates of urological/ prostate consultations in general practice, the number of urological appointments and waiting times for urological appointments. The study is taking place in Coventry PCT and in

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<sup>3</sup> Office for National Statistics latest report showed a 7.2 percent difference in the five-year survival rates between the most affluent and the most deprived areas.

three control areas: Croydon, Ealing and Harrow. The interim report is due at the end of February 2007 and the final report in June 2007.

The qualitative evaluation is the subject of this report.

## 2. THE QUALITATIVE EVALUATION

This section explains the qualitative evaluation's aims and objectives, the limitations of the evaluation, and how the data was collected and analysed.

The evaluation of the qualitative aspects of the evaluation, due to a number of delays, was not commissioned until near the end of the pilot project (October 2006) and after the month's campaign was near its end. This meant that the evaluation looked retrospectively at the initiative in drawing conclusions on its impact. With this in mind, the evaluation's aims and objectives were as follows:

### **2.1 Evaluation aims and objectives:**

- To assess the impact of the project in raising men's awareness of the prostate and its function in the target groups
- To capture any unintended consequences of the initiative
- To assess how far ContinYou reached its project aims and objectives, exploring the assumptions of what would work, and the successes and barriers that contributed to its progress

### **2.2 Limitations of the evaluation:**

Due to the late commissioning, there are inevitably a number of limitations to the evaluation. These include:

- Commissioning at the end of the project prevented evaluation input into the development of the project, and the support required to keep it focused on its outcomes
- Late commissioning of the evaluation did not enable strong relationships to be built with local stakeholders and valuable data was lost
- A key member of the local team was unable to be interviewed because she had left the project as the evaluation began
- There were severe restrictions in accessing receivers of the messages because ethically it was not possible to prepare recipients in advance
- The trail, particularly in the community, went cold quickly, so it was difficult for some sources to recall impact (field work one month after the campaign finished)
- Due to the above, small numbers of receivers of the messages were contacted so it has been difficult to assess the impact on the target group. However, inferences have been drawn from the conversations with several intermediaries
- It was not possible to draw robust conclusions of the impact of not using the 'cancer message' as too few receivers interviewed

### **2.3 Collecting the data**

The evaluation adopted a number of different data collection methods to reach its aims and objectives. These included:

- Understanding the context and background to the project through reviewing:

- policy documents and relevant websites
  - literature and health promotion theories
  - steering group minutes
  - briefing notes and campaign materials
  - project plans and project meetings
  - focus group notes
  - media broadcasts and press releases
  - local evaluations and training sessions
- Interviewing five key stakeholders and three key project staff through one to one, face to face and telephone interviews, including the Department of Health policy lead for cancer screening and male cancers, the helpline service manager, the African Caribbean community worker and the Prostate Cancer Charity community involvement manager.
  - Focus group of six members of the local project team, to test assumptions about the project and the successes and barriers that contributed to its progress (Appendix 2)
  - One to one interview with two receivers of the local authority intervention (Appendix 3)
  - One to one interviews with nine receivers of the awareness campaign, including community leaders acting as intermediaries to the target groups
  - Observations and conversations<sup>4</sup> in approximately 25 percent (8) of the community venues including pubs, social clubs and leisure centres, and with six of the GP surgeries and community pharmacists in those wards targeted by the October campaign
  - A further telephone survey was carried out of 20 percent (21) of the GP practices and community pharmacies across Coventry

## **2.4 The analysis**

The analysis used the theoretical framework of the communication – behaviour change health promotion model described below (3.4), which was also used in the pilot project design. The data was linked and categorised in order to draw inferences<sup>5</sup>.

## **2.5 Findings**

In December 2006, the interim findings of the evaluation were fed back to the project team in Coventry. The purpose of this was to correct any factual inaccuracies in the report, and to engage the team in the learning outcomes from the evaluation. Following this meeting, the report was refined.

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<sup>4</sup> Conversation sampling is a method of analysing societal attitudes by listening techniques, and is particularly useful when sampling in public places. One disadvantage of this method is the amount of irrelevant conversation that can be included, and topic and content can change. See Ann Bowling (2002) *Research Methods in Health*, Open University Press, and Silvermann, D (1993) *Interpreting Qualitative Data*, London: Sage Publications

<sup>5</sup> Ann Bowling (2002) *Research Methods in Health*, Open University Press

### **3. THE PILOT PUBLIC AWARENESS PROGRAMME**

This section looks at the context where the pilot project took place, the groups that were the target of the campaign and the two theoretical models that formed the rationale for the project's design. These are a social model of health, and the communication-behaviour change health promotion model.

#### **3.1 The Context - Coventry Primary Care Trust**

The pilot took place in Coventry Primary Care Trust (PCT). It is a Spearhead PCT with significant areas of deprivation<sup>6</sup>. Coventry ranks in the highest quartile of areas for deprivation (50th out of 354). Ten of the 18 Coventry electoral wards are in the highest fifth of the electoral wards nationally for deprivation, with only one ward (Wainbody) in the least deprived fifth. The difference in average age of death between wards has remained at approximately ten years over the last decade, whereas life expectancy in all areas has increased by approximately three years.

One in five Coventry residents are from an ethnic minority background. Some of the major communities include Foleshill, St Michaels and Upper Stoke. People from these communities make up a particularly sizeable proportion of the population in the north and north-west of the city. The programme targeted its community campaign in these areas (appendix 4).

During the time of the pilot, the National Health Service (NHS) was undergoing a significant service re-configuration. However, Coventry was one of the few in England that was remaining the same and therefore, potentially, offered a degree of stability and continuity to support the work.

#### **3.2 The target groups**

The programme aimed to target all men in Coventry over 50 years of age, and, within that group, to pay particular attention to:

- Men with a family history of prostate problems
- African and Caribbean men
- Men living in the most deprived wards with poor health outcomes

The project had to abandon its aim to reach men with a family history of prostate cancers because of ethical constraints (described in 4.1), but was successful in reaching men in the generic age group, those in deprived wards and some of African Caribbean descent.

#### **3.3 Adopting a social model of health**

The project aimed to explore different settings for health promotion within the PCT, such as primary and secondary care, in the workplace and in leisure and community settings. The team wanted to use a social model of health, rather than a medical

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<sup>6</sup> Coventry PCT Local Delivery Plan 2006 - 2009

model, as it was in keeping with the aims of the pilot programme. This model supports the World Health Organisation's definition of health, defining the social model of health as:

“a conceptual framework within which improvements in health and wellbeing are achieved by directing effort towards addressing the social and environmental determinants of health, in tandem with biological and medical factors”.<sup>7</sup>

This meant that partnerships, participation and community development were central to its design.

### **3.4 Communication-behaviour change model**

The method used by the pilot project to raise awareness was underpinned by health promotion models borrowed from social marketing and communication-behaviour change, and are a useful framework for designing health education campaigns (McGuire 1989)<sup>8</sup>. The communication-behaviour change model is based on a clear set of communication inputs and outputs. It involves engaging individuals and communities in the issues to be addressed, and developing clear communication between health promotion practitioners and those they are trying to influence (in Nutbeam and Harris 2004)<sup>9</sup>.

There are five *communication inputs* offered by the model:

1. *Source*: the person, group or organisation from whom the message is perceived to have come
2. *Message*: what is said and how its said
3. *Channel*: the medium used to deliver the message, eg media including radio and print materials, mobile phones, direct mail, word of mouth
4. *Receiver*: the intended audience, matching the right message to the right channel to the right source
5. *Destination*: desired outcomes in target group

The *communication outputs* follow a twelve-step sequence of events, which link exposure to a communication with a long-term change in behaviour<sup>10</sup>. These twelve steps are:

1. Exposure
2. Attention

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<sup>7</sup> Alice Ryan and Vicki Sarikoudis (April 2003), Paper presented at the 3<sup>rd</sup> National Homelessness Conference held in Brisbane.

<sup>8</sup> WJ McQuire (1989) 'Theoretical Foundations of Campaigns', in Rice, RE and Atkins, C (eds) *Public Communications Campaign*, California: Sage.

<sup>9</sup> Don Nutbeam and Elizabeth Harris (2004) *Theory in a Nutshell: a practical guide to health promotion theories*, second edition, Sidney, Australia: McGraw-Hill

<sup>10</sup> De Vries (1991) simplified this to six outputs: attention, comprehension, attitude, social influences, self-efficacy and behaviour, in *ABCs of Health Education and Health Promotion*, Maastricht: Department of Health Education.

3. Interest
4. Understanding
5. Skill acquisition
6. Attitude change
7. Memorisation
8. Recall
9. Decision-making
10. Behavioural change
11. Reinforcement
12. Maintenance

Therefore, the intended audiences have to be exposed to the message, pay attention to it and understand it. If this takes place, there are still eight more steps to the achievement of sustainable behaviour change.

The use of this methodology to deliver the pilot project meant that the evaluation, by adopting the same theoretical framework, can test both inputs and outputs of the activities to obtain the clearest results. The outputs are useful as indicators of success against the project assumptions of what may be achieved. The project team recognised from the outset that a short-term project like this would be unlikely to achieve all these twelve steps. However, they hoped to reach step eight 'recall'.

The analysis that follows uses this communication model as a framework for the results.

## 4. ANALYSIS OF THE COMMUNICATION INPUTS

This section analyses the four communication inputs from the communication-behaviour change model that were used by the project to make an impact and the rationale behind them. The four inputs are: the source, the message, the channel and the receiver.

### **4.1 The Source**

ContinYou, who had responsibility for leading the project, brought together a core project team with representatives from Coventry Primary Care Trust health promotion department and Coventry City Council's health development team. Across this core team was expertise in workplace health, men's health, community development and outreach, health promotion, addressing health inequalities and engaging with the African Caribbean community.

The sources, or routes, the project used to develop and deliver the awareness campaign were partnerships with statutory organisations, interest groups and organisations in the community, as well as engaging individuals who would have credibility and relevance to different target audiences.

The campaign month was finally agreed as October 2006 and four sources, or interventions, were identified to reach the target groups in that month. These were a workplace intervention, gaining access to men through an NHS acute Trust, individual contacts with an African Caribbean worker and fourthly, involving interest groups and organisations in the community.

#### **A workplace presentation for reaching men over 50 living or working in Coventry:**

The City Council health development team had experience of working with men in the workplace, and had a member of staff dedicated to improving men's health. The team had initially aimed to reach men in semi skilled roles within the council, such as grave-diggers and refuse collectors. However, because these employees work away from the central offices, are paid by the hour and carry out shift patterns, it was difficult to access this group in the time frame. Secondly the team had planned to build on earlier work in one of the local factories, but the factory announced considerable redundancies and it was therefore inappropriate to continue. A decision was therefore made to target men over 50 who worked in one of the Council buildings. The trade union was not involved.

#### **Local NHS acute Trust for men with a family history of prostate problems**

The most effective way to reach this group was considered to be through working with the local NHS acute trust or Primary Care Trust to identify patients with a family history. The acute trust was very willing to co-operate but local ethics committee approval was required to satisfy research governance and this was not possible in the time scale. Therefore this group were not directly targeted although it is safe to assume, and indeed was the case, that some men with a family history of prostate problems would be reached through the other sources.

## Informal meetings with African and Caribbean men

Through the findings of a focus group with African Caribbean men, and face to face discussions, it was decided that the PCT health promotion department would employ an African Caribbean man, with experience of community development to engage older Black men in community settings. These were to be informal, one to one discussions or presentations at venues where Black men met together. The organisations reportedly targeted by the community worker included:

- Manager of the Cariba Project at the West Indian Centre
- West Indian Community Centre - patrons at the bar
- Daddy Bs Caribbean takeaway
- The Vincentian National Association
- A local Cricket Club (Radford, Coventry)

## Community development approaches for men living in the most deprived wards with poor health outcomes

The project was piloting a social model of health (3.3) and therefore a community development approach was considered the best way to reach communities that had poor outcomes and which health professionals sometimes find difficult to reach. These communities were mainly in the north and north-west of the city.

## Public house used in campaign



In particular, the project worked through a range of intermediaries<sup>11</sup> in voluntary sector organisations, leisure centres, public houses and social clubs. Men of African Caribbean descent and men with a family history of prostate problems were also reached through this source. The campaign materials (the 'message') were delivered in person to 23 community venues within the area described.

Half way through the year, the national steering group requested that all the general practitioners (GPs) and community pharmacies in Coventry should receive the campaign materials. The materials were sent by post to all 76 GP practices including branch surgeries, and 82 pharmacists, with an accompanying explanatory letter. The packs were sent to named practice managers and pharmacists respectively.

### **Men's toilet in the Hope Centre**



### **Briefings and training**

Briefing papers were prepared for the face-to-face sessions in the community, as well as a script for the delivery of materials to community venues (appendix 5). Letters to accompany the materials to GPs and Pharmacists were agreed so that all the team were a source of consistent campaign messages.

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<sup>11</sup> An 'intermediary' in this context is described as a go-between or mediator.

In August, prior to the campaign month, the core team attended a one-day training session delivered by the community involvement manager from the Prostate Cancer Charity (appendix 6). The purpose of this training was to give the team information on the prostate and its function, so they would be prepared if questions were raised during the intervention phase.

### **GP practice in Foleshill**



### **4.2 The Message**

This section considers the content and form of the message, what was said and how.

#### **Key messages (appendix 1)**

The key messages had been drawn up nationally by the Prostate Cancer Advisory Group (see Background: 1) to ensure consistent, clinically agreed information was being given. However, the form and approach to deliver these messages was developed through working with the target audiences. For example, a comment from an African Caribbean man was that: *"The best way of raising awareness is to have some relevant marketing of Black communities, which are (at the moment) disengaged"*. This fits with the evidence that, if materials are to be effective in

raising awareness, they need to be developed with the people for whom they are intended (Bevan 2005)<sup>12</sup>.

It is also worth acknowledging that in this process of developing the materials, awareness among the target groups is being raised.

### **Developing the campaign materials**

ContinYou drew on previous experience of a men's health campaign<sup>13</sup> for an initial draft of the campaign materials, and then worked with focus groups from the target audiences to refine them. Two small groups were held in May, one with African Caribbean men aged over 50 at a local community centre, and another at Warwick University with working men and women. These focus groups looked at current knowledge about the prostate, what do people want to know, what source would be acceptable, how best to convey the key messages, the appropriate channels and who should receive them. The African Caribbean community worker also had face-to-face discussions with Black men about the materials.

In July, one of the groups, at Warwick University, was reconvened to look at the prototype materials and make final adjustments.

Two issues were prominent in the discussions:

#### ***(1) The use of 'scare tactics', or playing down the cancer risk***

This was a matter that had been raised by the PCAG, and both the focus groups agreed that strong messages about prostate cancer would mean men would disengage from the campaign. For example:

*"Just have a list of symptoms. Scare tactics don't work. It starts out scaring the hell out of you". "Say it's a simple problem". (African Caribbean focus group)*

The final products reflected these issues by focusing more on prostate function rather than prostate cancer. The less and more serious messages were also separated out. The emphasis on prostate health rather than prostate cancer was used in the instructions to all team members carrying out interventions, whether that was going to the pubs and clubs, talking to Black men on a one to one basis, or doing a presentation to local authority workers.

#### ***(2) The use of humour to reduce embarrassment***

The view from the groups was that humour was a good idea because it reduced men's embarrassment to the issues. The project team had originally been unsure

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<sup>12</sup> Bevan, H (2005) *Five emerging trends in healthcare improvement*, in Health Service Journal, 29<sup>th</sup> September 2005

<sup>13</sup> Men's Health Forum, CEDC and University of Warwick (2003) *Out of the Water Closet; a project to increase men's awareness of prostate health in the workplace*. London; Men's Health Forum

about the slogan “*Don’t dick about, see your doctor*”, and the cartoon figures of firemen with dripping hoses. However, experience from previous work at ContinYou and feedback from the focus groups supported this approach. One African Caribbean elder was reported as ‘chuckling’ when he saw the leaflet. It was further endorsed when visiting the pubs and clubs after the awareness month; the managers we spoke to remembered the slogan and had joked with their customers.

The issue of having a black fireman figure was considered but the view was that as these were cartoon characters, and the messages were going to be delivered face to face rather than primarily through posters, it was not so relevant. The evaluation was unable to fully test the hypotheses due to the lack of access to black participants (described in 4.4).

Following the focus group the space was widened between the lettering and the illustrations adjusted, high-risk groups were added to the leaflet and general messages were given prominence over cancer ones.

The final products distributed during the campaign month of October 2006 were:

- 8987 leaflets - it is estimated that all were taken up
- 995 drink mats – all taken up
- 500 posters

### **4.3 The Channel**

The channel is the means by which the message will be conveyed. As usual in a campaign of this nature, a number of different channels to reach the target groups were used, and the choice of channel was also part of the focus group discussions. The campaign chose: media sources, printed materials, face-to-face interventions with the African Caribbean community, a presentation to the City Council workforce within one setting, and working with community intermediaries. This section also looks at the Helpline support.

#### **The Media**

A local radio appeal was broadcast in May to recruit men for the focus groups to develop the materials. There was also a press release in the local newspaper and in the Black press (appendix 7). There was one recruit from this appeal to the African Caribbean group.

At the start of the October campaign, a broadcast was made on local radio that was repeated throughout the day after the news bulletin. A press release was issued to the local papers but did not feature. It is not clear why it did not appear and it was not possible to follow this up due to the time lag of the evaluation. There were no targeted broadcasts about the campaign to Black radio stations or in Black print media.

There was no concurrent national media campaign either on prostate health, or men’s health in general, which may have lessened the impact of the local media messages.

## **Printed materials**

Leaflets, beer mats and posters were considered an effective channel for raising awareness among men aged over 50 years in community venues in Coventry. As discussed in the previous section on the message (4.2), a great deal of time was spent in ensuring that the printed materials were appropriate, and that the same message about the campaign approach was used.

## **Face to face interventions**

Through the early investigative work, it was decided that the most effective way to reach African Caribbean men was through face to face meetings between a Black man and the community. The community worker was to use the campaign materials to guide discussions.

## **Formal presentation in a workplace setting**

As described in the 'source' (4.1) the City Council's health promotion team engaged men over 50 who lived or worked in Coventry through an intervention carried out in the workplace. The channel they used was a PowerPoint presentation in the conference room at a City Council building. The flyer to advertise the event (appendix 8) was displayed in all the men's toilets, and 300 emails were sent to the people in the building.

The presentation was made available by the Prostate Cancer Charity and had been used in the training. It was delivered by the Senior Health Development Officer at the City Council, with support from her team, followed by an informal question and answer session at the end. Three men attended.

## **Community intermediaries**

The channel chosen to reach older men in deprived communities was through working with members of the community who are in contact with the target group. Intermediaries included public house landlords, leisure centre managers, specialised local voluntary sector organisations, pharmacists and GP practice managers.

## **Helpline support**

It was recognised that during an awareness campaign, it is important to make available an opportunity for people to seek further help if necessary. A local PALS (Patient Advice and Liaison Service) had capacity to be a contact point for enquiries, and the telephone number was put on the campaign materials. The service was well briefed in the campaign by the project team, with further information sources identified. The PALS service had concerns that they may receive a deluge of enquiries, but in the end only two enquiries were received during the October campaign.

#### **4.4 Receiver**

This section explores the fourth communication input, 'the receiver', and whether the intended audiences received the right message through the right channel from the right source.

Men over 50 years of age living and working in Coventry accessed the project through the workplace initiative: 3 men attended the presentation, and there was informal peer-to-peer exchanges, and opportunistic discussions with the local authority health professionals. Men in this group would also be reached through the community development work.

The source to directly engage men with a family history of prostate problems unfortunately was unsuccessful due to timescales for ethic approval. However, there was evidence during the observation visits that some people in this group had received the messages.

It has not been possible in this evaluation to know whether African Caribbean men received the message from the source agreed (4.1). The evaluator was unable to interview any men who had been exposed to the informal meetings because of lack of introductions and the time delay from interventions to evaluation. However, it is clear from evidence of the community development approaches that some Black men did receive the messages through community intermediaries.

Men living in deprived areas wards were exposed to the messages through the settings used.

The Helpline, managed by the PALS service, received two enquiries, both from men in the 70s, with difficulty in passing urine. They were advised to go to their GP.

## 5. THE IMPACT

This section looks at the impact of the awareness campaign on the four target groups of men in Coventry. This is the 'destination' of the communications-behaviour change model that measures success against the inputs. It includes three case studies to illustrate the impact.

### **5.1 Changing behaviour in the target groups**

The evaluator explored with the project team what they assumed would be the impact<sup>14</sup> of the pilot awareness campaign in changing the behaviour of men aged over 50 in Coventry. This was measured against the twelve-step sequence<sup>15</sup> of outputs, which links exposure to a communication with long-term change in behaviour. Their expectations varied between the target groups, from 'interest' in the African Caribbean group to 'recall' in professional men who worked at the City Council.

### **5.2 Results**

#### **Impact on men over 50 years living or working in Coventry**

The intervention was the presentation and discussion in the workplace. The evaluator observed the intervention, and two of the three men who attended agreed to be interviewed. Analysis of the questionnaires showed the following against the communication outputs:

- *Exposure* – two professional men (Local Government Officers) attended the presentation. Neither participant had been aware of the wider campaign taking place in Coventry
- *Interest* – one man was motivated to attend because his father has benign prostatic hyperplasia
- *Understanding* – both men learnt about the difference between unaggressive and aggressive cancer, and had existing knowledge confirmed
- *Skill acquisition* – about PSA testing and implications
- *Behaviour change* – both men planned to enquire about PSA testing when they next visited their GP.

Due to the very small numbers attending it is not possible to generalise these findings. However, they do show that in professional men the awareness raising led to a behaviour change.

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<sup>14</sup> 'Impact' is defined as all changes resulting from an activity, project or organisation. It includes intended and unintended effects, negative as well as positive, and long-term as well as short-term, Susan Wainwright (undated), *Measuring Impact: A guide to Resources*, NCVO publication.

<sup>15</sup> The twelve steps are exposure, attention, interest, understanding, skills acquisition, attitude change, memorisation, recall, decision-making, behaviour change, reinforcement and maintenance.

## Impact on men of African origin

It has been difficult to measure the impact on this group because of the problems the evaluator had in accessing men and women receiving the interventions from the African Caribbean community worker. However, the evaluator did have conversations with seven men who were intermediaries for this group, and they reported exposure to the messages. The intermediaries were positive about the interventions, and stressed how this linked with increasing interest about prostate cancer from relatives in the homelands.

- *Exposure* - patchy due to issues with source and channel
- *Attention* – probable through enthusiastic intermediaries
- *Interest* – probable due to involvement of trusted intermediaries

### **Case study - intergenerational learning**

At one of the social club venues, a young Black man joined the conversation about the impact of the campaign. He said that he had taken the materials home to his father, because he thought it was important for him to have the information. The son had developed an understanding of the issues through the campaign and passed this onto his father. He said how it also reinforced the messages that were coming from the homeland (Caribbean Islands) about the risk to African Caribbean men of prostate cancer.

## Impact on older men living in the most deprived wards

The data collection for assessing this group came through observation visits in a sample of locations, and holding opportunistic conversations with people who had supported the campaign, and were the source of the message. Conversations were held with public house landlords, leisure centre managers, community leaders, community pharmacists, pharmacy staff, GP receptionists and practice managers. The data was further supplemented by telephone interviews with practice managers and pharmacists. This represented in total approximately 30% of the venues in the wards that were targeted for the campaign.

Inferences can be drawn from these conversations about the possible impact on the target group. No direct receivers were spoken to because the campaign month had finished; nearly all of the leaflets and drink mats had been taken, and consequently, in many cases, the staff had removed the posters. The ones we did observe did not have graffiti on them.

Most of the pharmacists that were contacted could not remember receiving the materials, and many did not have space to display them. However, some said that they would have been willing to take part. None had received any feedback from customers. Similarly with GP practices, the response was mixed with some claiming no knowledge of the materials. One surgery though had given the materials to the practice nurse and she had found them very useful with patients. She requested more leaflets.

The impact on this group of men is therefore drawn from an analysis of these observations and conversations:

- *Exposure* – 23 community venues where older men spend time were targeted with the materials.
- *Attention* – the target group had their attention drawn to the materials through community representatives, community leaders and family members
- *Interest* – very significant because of the number of leaflets and drink mats that were distributed, estimated as approximately half the total campaign materials, ie 4000 leaflets, 500 drink mats, 200 posters. Some of the posters were still on show in the men’s toilets

#### **Case study – Social club manager**

A social club manager, who was himself in the target age group, had taken a selection of the materials to his local club to give to: “men of my age that I drink with”. He said that men would not go to their doctor for this information because: “men are funny like that”.

#### **Case study - Community Intermediaries**

The Hope Centre is a community resource centre in the heart of one of Coventry’s most deprived areas, Hillfields <http://www.hope-centre.com/>. The project co-ordinator described the role of the Centre as “translating for the community”, acting as “an introduction agency” through engaging with people who would not typically use traditional health care facilities, and building up trust. The Centre links people together and sign posts them to information and services. In particular they engage with community leaders from the Congo, Somalia and Burundi. The Hope Centre sees it has a role with awareness campaigns such as this one, and willingly put up posters in the men’s toilets and left leaflets in the coffee bar. They also took the materials to outreach events, eg a local bonfire, and instigated discussions. The only issue raised was that sometimes, during a campaign, local issues can overshadow it; in October, during the campaign, there was a shooting in the Kurdish Community.

#### **Impact on men with a family history of prostate problems**

As stated earlier, the pilot project was unable to specifically reach this group because the channel they had chosen to reach this group, that of patients at the local NHS acute trust, required ethical approval. This proved not possible in the timeframe of the project.

However, it would not be unreasonable to infer that men in this group will have been *exposed* to the campaign through the workplace, one to one interactions with the African Caribbean worker and the community initiatives.

***Case study – family history of prostate cancer***

An opportunistic conversation took place during the workplace intervention. A security guard at the City Council, who knew the health development team, was asked why he did not attend the session. His response was that there were currently some of his family members having investigations and treatment for prostate cancer, and he did not want to hear anymore about it.

## **6. LESSONS FOR FUTURE CAMPAIGNS**

The final section considers the learning from this pilot initiative for informing the development of future campaigns. It looks at what worked well, what worked less well, the unintended consequences and key learning points, linking current health policy initiatives with spreading the learning to other areas.

The work in Coventry to raise public awareness of the prostate and its function was a pilot programme, which, as well as measuring the impact of the programme on target groups, produced considerable learning for future campaigns and the spread of innovative practice.

### **6.1 What worked well?**

- Using humour in the campaign materials
- Developing the materials with target groups
- Reaching men in deprived wards through adopting a social model of health to the programme
- Engaging enthusiastic intermediaries who acted as channels for the information

### **6.2 What worked less well?**

- Unable to directly target patients and their relatives with a history of prostate cancer due to ethical processes
- Sending materials to GP surgeries and community pharmacists had little impact on exposure
- Working relationship with the Primary Care Trust was limited due to different priorities
- The channel used to deliver the workplace intervention may have limited the number of attendees. There was no evidence to suggest this was due to the subject matter, or concerns about cancer
- Access for the evaluator to interview African Caribbean men targeted by the Black Community worker did not take place

### **6.3 What were the unintended consequences?**

- The role of the local authority in improving health and reducing inequalities was clearly identified, and relationships built which would enable further local health partnership work
- The enthusiasm and key role of community intermediaries was identified and could be further developed
- An opportunity was provided for groups with poor health outcomes to use the campaign to promote other agendas, in particular African Caribbean men and their dissatisfaction with local services
- More campaign materials were requested by local organisations after the campaign month had finished
- Agencies outside Coventry, when they heard about the campaign at a conference, were keen to receive and use the materials in their localities

## **6.4 Key learning for future campaigns**

- Developing materials for the intended recipients is essential for getting the message right. It also forms part of the awareness-raising process.
- Future local campaigns could benefit from being linked into national awareness initiatives. This reinforces and helps people to make connections between national and local messages.
- Ethical considerations must be automatically built into the very early planning decisions for small-scale, tightly timetabled pilot studies.
- The role of community leaders, peer educators and other community intermediaries, such as public house landlords and leisure centre managers, cannot be underestimated. They demonstrated a role in promoting health messages in communities of significant disadvantage where professionals find it difficult to reach.
- Resources spent in training and briefing of these intermediaries could spread the understanding of the messages and support behaviour change.
- Discussions with local Community Pharmacists on the best way to involve them in awareness raising issues would be beneficial. Similarly with GP practice staff; receptionists could be briefed to promote the campaigns.
- Lessons could be taken from social marketing techniques which develop different approaches to reach different age cohorts of older men, such as those in midlife, men between 65 and 75 and those over 80 years of age.

### **Links to health policy**

- The new contractual framework for community pharmacy, enhanced GP services, the new Commissioning Framework for Health and Wellbeing and practice based commissioning may all provide policy levers for the NHS to better support awareness campaigns.
- Public health policy on NHS health trainers and NHS midlife health checks, for people aged around 50 years old, could be linked to health awareness campaigns and support behaviour change.

### **Spreading the learning from pilot programmes**

- It is useful to consider the mechanisms for spreading the findings from pilot programmes and replicating 'what works' whilst the pilot is still operational and before valuable knowledge and experience of practitioners is lost.

## Appendix 1: Key messages

### Agreed key messages

#### What is the prostate?

- The prostate is only found in men. It is very important for a man's sex life, producing some of the fluid in semen. It is found below the bladder and is about the size of a walnut. It surrounds the tube that carries urine from the bladder
- When something goes wrong with the prostate, it can affect a man's sex life, his long term health and with prostate cancer can lead to death

#### What can go wrong with the prostate?

- Benign disease (Benign Prostatic Hyperplasia - BPH) – the prostate slowly gets bigger as men get older, and in some can cause difficulty when passing urine as the growing prostate puts pressure on the tube that carries urine from the bladder. BPH is treatable and is rare in men under 50
- Prostatitis – this is normally an inflammation of the prostate gland and can cause difficulty and pain when passing urine. Prostatitis is treatable and can occur in men of any age
- Prostate cancer – a single cell in the prostate begins to multiply out of control and forms a tumour. Some cells may break away and travel to other parts of the body, starting new tumours. Prostate cancer is treatable and can be cured in many cases. It is rare in men under 50 but gets more common as men get older

#### The symptoms of prostate diseases are similar:

- Needing to urinate often, especially at night
- Difficulty in starting to urinate
- Straining to urinate or taking a long time to finish
- Pain when urinating or ejaculating

#### Other, less common symptoms that may be prostate cancer are:

- Pain in lower back, hips or pelvis
- Blood in the urine (this is unusual)

However, these symptoms are often something else and not cancer.

Prostate cancer is different from most cancers – some prostate cancers grow slowly and may not cause problems, but some grow quickly and need early treatment.

If you are worried about any of these symptoms, you should go and see your doctor.

#### Where can I get further information?

NHS Direct On-line: <http://www.nhsdirect.nhs.uk/>

## Appendix 2: Focus group guide

### Evaluation of pilot public awareness programme on the prostate and its function

#### Focus group discussion guide

**Participants:** project leads

#### **Aims of session**

Assess how far ContinYou reached its project aims and objectives, exploring the assumptions about the pilot project and the successes and barriers that contributed to its progress

#### **Ground rules**

- Listen to each other
- Confidentiality

#### **Tape recorder**

**Ice breaker:** “What would you like to be doing if you weren’t here?”

#### **Starter/ discussion question**

“How did you each get involved with the project in the first place?”

*Few minutes to write down, all participate*

#### **Guiding discussion questions**

1. Original aims of the project – assumptions/ theories

- What did you think would happen?
- Why did you think that would work?

2. Communication- behaviour change model of health promotion (*use for further probing*)

- **Source** – someone respected by the target group, whom they identify with
- **Message** - portrayed in a way that was acceptable
- **Channel** – media and mediums used by men, location
- **Receiver** – target group right? Significant others
- **Destination** – what were the materials seeking to achieve? Full behavioural change or .....

### 3. Successes and barriers

- What has worked well?
  - Access, materials, partnerships
- What has worked less well?
- What have been some of the barriers?

### 4. Where do you think you got to on this sequence of events for changing men's behaviour towards prostate health awareness? *Put on cards*

- Exposure – to the message
- Attention – pay attention to it, hear it
- Interest
- Understanding - and understand it

#### *still 8 more stages to achieving behaviour change*

- skill acquisition
- attitude change
- memorisation
- recall

#### *project expectation*

- decision-making
- behaviour change
- reinforcement
- maintenance

### 5. What have you learnt from this project? Is there anything you would have done differently next time?

#### **Final summary question**

“What do you think has been the greatest impact of your project on the men of Coventry? Now.....6 months..... 2 years.

**Gillian Granville**  
**November 14<sup>th</sup> 2006**

**Appendix 3: Interview questionnaire**

**Evaluation of pilot public awareness programme  
on the prostate and its function**

**Interview questionnaire**

**Age range:** 45 to 50, 50 to 55, 55 to 60, 60 to 65: .....

**Occupation:** .....

**Do you live in Coventry?**

**General awareness**

Did you know about the Coventry prostate health awareness campaign, which took place during January?

Have you seen any of the posters/ beer mats/ leaflets that were distributed **outside** Broadgate House?

Do you have any comments on the materials produced?

- Were they relevant?
- Was the language appropriate?
- Were they easy to understand?

**Session in Broadgate House October 31<sup>st</sup> 2006**

How did you hear about the awareness session in Broadgate House?

What did you think it would be about?

What did you enjoy about the session?

What 3 things did you learn from the session?

1. ....

.....

2. ....

.....

3. ....

.....

Was there anything that could have been done differently? Please include alternatives suggestions if possible:

- Timing.....
- Venue.....
- Format.....
- Presenters.....

**Follow on**

Have you discussed prostate health with any of your colleagues? Before/ after the session?

Did you discuss it with any of your friends and/ or family?

Is there anything you will do differently as a result of attending the session?

**Thank you very much for completing this questionnaire.**

Appendix 4: Map showing some areas of Coventry



## **Appendix 5: Briefings for community venues**

### **Prostate Awareness Programme**

#### **Script for Pubs, Clubs & Leisure Centres**

**Initial contact by Phone ( Kulvinder has list of venues)**

**Hi, Can I speak to the manager. I am from ContinYou, a charity. We are running a campaign about men's health. It is aimed at men over 50. Do you have many men of that age coming to your pub? It is specifically about their prostate and what to do if they have problems.**

**I wonder whether your pub/social club/leisure centre would be willing to display some campaign posters, leaflets and drinks mats.**

**What we would be grateful for is your help in is:-**

- 1) Displaying the posters in men's toilets – at eye level when they are standing up and on the back of the cubicle doors.**
- 2) Put drinks mats on tables.**
- 3) Place leaflets where men can pick them up without drawing attention to themselves.**

**If they say yes then agree date and time to deliver them with accompanying letter.**

## Appendix 6: Training event for facilitators

### Programme

Event	One Day Training Session for Facilitators
Venue	Room 208, Christchurch House, Coventry
Date	Thursday 31 <sup>st</sup> August 2006
Times	10.00 – 16.00
Trainers	Ali Orhan - Community Involvement Manager Patricia Cohen - Support & Specialist Information Nurse

09.30 – 10.00 Registration

10.00 – 11.15 Introductions  
Setting the Scene  
Predisposing Factors  
Risk Factors  
Statistics

11.15 – 11.30 Tea Break

11.30 – 13.00 The Prostate Gland  
Anatomy & Physiology  
Prostate Problems  
The Diagnostic Pathway  
Staging Prostate Cancer

13.00 – 14.00 Lunch

14.00 – 15.30 Treatments – Staging the Disease  
Treatments – Advantages & Disadvantages

15.30 – 16.00 Working with the Community

16.00 End

## **Appendix 7: Press release in Limelight**

### **HELP US TO IMPROVE THE HEALTH OF COVENTRY MEN**

**Are you a male over 50 from the African Caribbean community?  
Do you have a male relative over 50 who has had a prostate problem?**

#### **Men's Health Project - £45 payment to take part in 3 meetings!**

The Department of Health is keen to raise Coventry men's awareness of the prostate and how it works. ContinYou, a national charity based in Coventry, will be leading the campaign later this year. Prostate problems mostly affect men aged over 50 so we are seeking men of that generation to take part in just 3 meetings from May to September to advise us on how the campaign can be as effective as possible.

The meetings will last about 2 hours each at a city centre venue and at a time to suit you. During each meeting you will be given information about the prostate and you will be asked to comment on things like leaflets and posters. We will pay you £45 expenses if you attend all 3 meetings as a thank you for your time and effort.

If you are interested in taking part and you can tick one of the boxes below then please fill in the reply slip and send it back to me by 16 May 2006 either by posting the reply slip below or by email to me at [jonathan.berry@continyou.org.uk](mailto:jonathan.berry@continyou.org.uk). My address is ContinYou, Unit C1, Grovelands Court, Longford Road, Exhall, Coventry CV7 9NE.

Your participation in these meetings could help improve the health of other men in Coventry. I would like to thank you for taking the time to read this and do hope that you will feel able to help us.

#### **Reply Slip**

I am interested in taking part in the prostate awareness meetings.

Please tick one or more of the following statements

I am a Coventry man aged 50 or over

I am related to someone who has had a prostate problem

I am from the African Caribbean community

Name (block capitals)

Age.....

Address

Daytime phone number, Email address



# Prostate Awareness Programme

- Are you a man over 50?
- Do you have a man in your life who is over 50?
- Would you like to know more about the Prostate?

**Don't be shy, come along to this informal session & have all your questions answered**

**Where: Conference Room A, 5<sup>th</sup> Floor, Broadgate House**  
**Time: 1.00 to 2.00 p.m.**  
**Date: 31<sup>st</sup> October 2006**  
**Who: Health Development Unit, Health Inequalities Team**

By the end of the session you will know answers to the  
questions below

**Where is the prostate?**

**How does it work?**

**What's it for?**

**What can go wrong & how to put it right?**

**Where can you get help?**



**FOR MORE INFORMATION CONTACT:  
Jean Arrowsmith, Senior Health Development Officer  
Telephone (024) 7683 1898**