

An evaluation of asthma education project targeting the Traveller and Roma community

Health Education Journal

2016, Vol. 75(4) 396–408

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DOI: 10.1177/0017896915592655

hej.sagepub.com



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Abstract

Objective: The aim of this evaluation was to determine the cultural and educational appropriateness of a pilot asthma education programme developed for the Traveller and Roma community in Ireland.

Design: A participatory multi-stakeholder and qualitative approach.

Setting: Prevalence and inadequate control of asthma have been found to be high among members of the Traveller and Roma community. Barriers to health care among these groups have been reported. A train-the-trainer approach was undertaken to build capacity among Traveller Community Health Workers around specialist asthma knowledge.

Method: A total of 29 Traveller community health care workers completed and graduated successfully with a certificate of attendance. Interviews were undertaken with key stakeholders ($n=8$) and focus groups ($n=24$) with participants.

Results: The train-the-trainer approach was shown to be an effective, transferable and cost effective strategy to building capacity to outreach specialist asthma education to a wider population. There was a very positive response to the programme among the stakeholders, facilitators and the participants generally. Participants felt confident in their ability to teach other health care workers about what they had learned during the programme.

Conclusion: The cascade provided by the pilot work offers an economical approach to building capacity and outreach specialist asthma knowledge to Community Health Workers and to families affected by asthma in the Traveller community. The use of energisers and the approach to local evaluation should be adapted to respond to the requirements of the group. It is recommended that regular evaluation and reporting of outcome indicators be undertaken.

Keywords

Asthma, capacity building, health education, Roma, 'train the trainer', travellers

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Introduction

Current prevalence of asthma is 300,000,000 worldwide, with 250,000 deaths annually attributed to the disease, the majority of which are avoidable (World Health Organization [WHO], 2007). The prevalence of asthma in Ireland has been estimated fourth highest in the world at 9.8% (47,000) of the total population (Asthma Society of Ireland [ASI], 2014) and is estimated to be one of the most common chronic diseases in children (ASI, 2014).

The prevalence of asthma and the inadequate control of asthma have been found to be high among members of the Traveller community and Roma community (Department of Health and Children, 2010). In all, 22% of the Traveller and Gypsy community report having asthma (compared to 5% in the main population) (Parry et al., 2004). The ASI is the national charity for people with asthma in Ireland. As part of the Society's work with disadvantaged groups and in response to specific requests, it became apparent that there was a need for a national and targeted asthma prevention and management education programme to the Traveller and Roma community. To capitalise on existing resources, a 'train the trainer' pilot asthma education programme was developed to increase the reach of specialist knowledge around asthma among this community. The authors were commissioned to evaluate the cultural appropriateness of the design and implementation of the programme as well as making recommendations for improvement.

Background

The most recent Irish census data from 2011 estimate the population of Irish Travellers to be somewhere around 30,000 people, accounting for 0.6% of the total population in Ireland (Central Statistics Office, 2012). According to the Equal Status Act of 2000 (Government of Ireland, 2000), Travellers in Ireland are defined as follows:

... the community of people who are commonly called Travellers and who are identified (both by themselves and others) as people with a shared history, culture and traditions, including historically, a nomadic way of life on the island of Ireland.

Consecutive studies have found that the health status of Travellers and Roma to be significantly lower than the general population (Cemlyn et al., 2009; Department of Health and Children, 2010; European Commission, 2014; Parry et al., 2004). Numerous studies confirm that this community reports higher levels of ill health than the main population (Cemlyn et al., 2009; Cumbria National Health Service [NHS], 2009; European Commission, 2014; Irish Traveller Movement Britain [ITMB], 2012; Parry et al., 2004; Peters et al., 2009). Mortality and morbidity rates for travellers are substantially higher and health outcomes for Travellers and Roma groups are found to be significantly lower (European Commission, 2014; ITMB, 2012). Life expectancy among this minority group has been found to be significantly lower than the general population (Cemlyn et al., 2009; Department of Health and Children, 2010; European Commission, 2014). Substandard accommodation in addition to shortfalls in site provision is a contributing factor to ill health in this community (Richardson and Ryder, 2012). Asthma was the most common reported chronic health condition in Traveller children, mirroring findings in the general Irish population which estimate that 21.6% of 13- to 14-year-old children report ever having asthma (Manning et al., 2007).

In addition to poorer health outcomes than general population (Van Cleemput et al., 2007), there are specific barriers to accessing health care for the Gypsy and Traveller community, including difficulties in communication, poorer literacy skills and reluctance to engage with health services (Bambra et al., 2010; Department of Health and Children, 2010; European Commission, 2014). In

addition, Pilson (2011) has reported that embarrassment and shame caused by poor literacy levels has led to miscommunication and failure to seek clarification on specific health instructions.

Many Travellers anticipate discrimination in accessing health care and have reported difficulty in getting registered with a general practitioner (GP), recording lower levels of satisfaction with health care (Van Cleemput et al., 2007) and that they are less likely to report that they feel respected or trust their health care provider (Department of Health and Children, 2010). Lack of cultural awareness among health care professionals is also a barrier to health care among the Traveller and Gypsy community (Francis, 2010; Van Cleemput et al., 2007). In response to these concerns and arising from the Primary Health Care for Travellers Strategy in Ireland, 40 Primary Health Care for Travellers Projects (PHCTPs) were established. These targeted initiatives incorporate wide ranging skills such as health education, policy development, research and training, designed to enable access to services in addition to networking and representation of Traveller–Roma interest (McCabe and Keyes, 2005).

Key to the success of PHCTPs is the Community Health Workers. While they are not health professionals, they are specifically trained and trusted members of the Traveller community who have access to the communities and are employed by the Health Services Executive on a part-time basis for up to 12 hours per week in varying numbers across community regions. Community Health Workers increase knowledge and access to health services for the Traveller community, and their role encompasses a number of activities including identification of health care needs, developing and disseminating health information and materials, advocacy at individual and community level and enabling dialogue with health professionals (CAN Action Learning Group, 2009).

A train-the-trainer approach is well established as a capacity-building strategy among the Traveller community enabling community participation and access to health care (CAN Action Learning Group, 2009; Swider, 2002). To maximise capacity and to capitalise on the role of the Community Health Workers, the ASI sought funding from the Health Services Executive in Ireland to design and deliver a pilot Asthma Education Programme to Community Health Care Workers in two primary care areas. In this train-the-trainer approach, asthma education is delivered within central hubs and then passed on to other workers creating a cascade or ripple effect, therefore increasing the critical mass of knowledgeable health care workers, maximising time and resources.

Overview of the programme

The pilot Asthma Education Programme was designed by the ASI in partnership with Pavee Point Traveller and Roma Centre in consultation with Community Health Workers and leaders of the PHCTPs. ASI provided the asthma expertise and staff from Pavee Point provided guidance on the specific teaching methodologies required by members of the Traveller community. These approaches took into consideration potentially poorer levels of literacy among the Traveller community and strategies to maximise concentration, that is, energisers. Two separate courses (comprising four 3-hour sessions) were delivered over 4 weeks at centralised locations within two different geographical regions. Specific teaching aids designed included an information leaflet, a poster and a pack which contained examples of the different types of inhalers and spacers as well as laminated asthma information sheets. These are to be used by the Community Health Workers when they were visiting Traveller families to educate them about asthma. An overview of the programme is provided in Table 1. Teaching strategies included tutorials, practical demonstrations, videos, case analysis, small group discussion and role play. Participants were awarded a certificate of attendance only if they attended all sessions and demonstrated proficiency in a practical examination of their competence using the inhalers. In total, 32 Community Health Workers commenced

Table 1. Overview of Asthma Education Programme content.

Week	Content	Duration (hours)
1	What is asthma, type, diagnosis, causes, risk factors and exacerbating factors	3
2	Asthma treatment and guidelines; management plan; self-management	3
3	Chronic Obstructive Pulmonary Disease, diet, immunisation, health promotion, school policy, ethnicity and cultural diversity, communication skills	3
4	Role play of training, summative assessment	3
Total contact time		12

the course with 29 successfully completing. Those who did not complete the course reported life events, for example, unforeseen illness, as the reason.

Aims

The overall aim of this study was to evaluate the Pilot Asthma Education Programme in terms of improvement in the participant's knowledge of asthma and their ability to transfer this knowledge to other members of the Traveller community. In addition to undertaking the evaluation, a second key objective consisted of establishing participant perceptions of the cultural appropriateness of the programme.

Methods

A qualitative design was used to collect the data. Members of the Traveller community are traditionally cited as a vulnerable and hard-to-reach community. Because of this, a participatory research approach as advocated by Brown and Scullion (2010) guided the methodological processes and assisted in identifying and engaging with the potential participants. Similarly, focus group interviews were used to elicit the views of the Community Health Workers as it was felt that they would offer a more relaxed and informal approach to data collection over individual interviews. They were held within 2 months of course completion and concentrated on establishing the participants' overall satisfaction with the programme, their knowledge of asthma following the programme, the cultural appropriateness of the programme and their preparedness to advise and educate other Community Health Workers and members of the Traveller community about asthma. Individual semi-structured interviews were also held with key stakeholders who were instrumental in the conceptualisation, funding, design and delivery of the programme. The aim of the individual interviews with key stakeholders was to discuss the key milestones that were achieved in the development of the programme, their perceptions of the programme and their aspirations in terms of the future sustainability of the programme.

Sampling

All Community Health Workers who undertook training ($n=32$) were invited to participate and were accessed through the PHCTPs using gatekeepers (Traveller Primary Health Care Coordinators) who provided information and assisted in arranging mutually agreeable times and locations for the focus groups. Five focus groups with 24 pilot Asthma Education Programme participants were

Table 2. Summary of focus group attendance.

Focus group	No. of participants	Gender, M/F	Completion status
Focus group 1	9	1/8	All complete
Focus group 2	4	0/4	All complete
Focus group 3	4	1/3	All complete
Focus group 4	4	0/4	1 non-complete
Focus group 5	3	0/3	All complete
Total	24	2/22	

conducted, and the majority of participants were female ($n=22$, 92%). The overall response rate was 75% of the 32 Community Health Workers, and attendance at the focus groups is summarised in Table 2.

One of the three non-completers also participated in focus group 4. The focus group participants' ages ranged from 25 to 73 years, and experience as Community Health Workers ranged from 2 to 20 years. Transport to and from the focus group was arranged, and Community Health Workers were reimbursed if they incurred any expenses. In addition, eight key stakeholders (commissioning body, community health coordinators, public health nurses, asthma nurses) who were involved in the design and delivery of the programme were interviewed. These were from the ASI, Pavée Point, PHCTPs, Public Health and the Social Inclusion Unit at the Health Services Executive.

Data analysis

The qualitative data from the focus groups and the interviews were audio recorded and transcribed verbatim and analysed, guided by Braun and Clarke's (2006) thematic analytical framework. This involved coding the data, identifying themes and relationships and identifying differences between participants. A set of themes and sub-themes was generated describing participants' experiences and views. Data were analysed by two researchers (A.-M.B. and B.K.) and findings compared. NVivo was used to assist in the management of the qualitative data.

Ethics

Ethical approval was granted from the Research Ethics Committee in the Faculty of Health Sciences, Trinity College Dublin.

Findings

The findings are discussed with respect to participants' overall perceptions of the programme, their knowledge of asthma following attendance, the application of this knowledge and the cultural preparation of facilitators and adaptation of teaching. Pseudonyms are used to protect the identity of participants.

Participant overall perceptions of the programme

There was an overwhelmingly positive response to the programme, and without exception, all of the participants suggested that they enjoyed the course and valued its contents. Words like excellent, interesting, effective and brilliant were used to describe the course and there was general

agreement that there was very little the participants could fault about the course or its content. In particular, the design of the programme which moved the emphasis away from written material and used discussion, practical demonstrations and less reliance on written text was welcomed. There was also a positive response to the teaching aids that were used during the programme. There was recognition that literacy levels among the Traveller community are sometimes poor and that the use of pictorials instead of written text was welcomed especially as the participants would have to eventually deliver the information to other Travellers. Furthermore, participants felt that all the relevant information required about asthma was contained in the poster, and the leaflet designed for use in the programme was in an easy-to-understand format:

It's very; all you have to do is look at it and know where you are. You know when you're giving the inhaler how much you're giving. You're overdosing with the inhalers so you don't know what to do. So when you go through the steps, you know which box you're in when you have to get to help. Where when you have to get help and when you don't. But I find it [the poster] very good. (FG 3: Gill)

There was also a positive reaction to the time that the facilitators took to go through the information with the participants. The additional time allowed the facilitators to develop a relationship with the participants, which aided their learning and general understanding of the concepts being discussed:

Well the two ladies that delivered it were excellent; they couldn't have delivered it any better. They were absolutely brilliant. As for the delivery, the women and the pace, I would have no fault with it. (FG 1: Gemma)

It was an open attitude, very supportive and if you did say something that veered off that wasn't let's say accurate, they were not at all dismissive of that, they were actually very open. (FG 3: Liam)

Participants also spoke about clear links between each of the sessions and how their learning was informally assessed in a continual way. A specifically designed questionnaire was used to test knowledge levels pre- and post-education sessions to ensure participants understood the concepts that were being covered by the facilitators. It comprised a visual analogue or scale traffic light system which relied more on pictures rather than text. This approach was designed to overcome the anticipated literacy difficulties that may arise among some participants. The mean knowledge level between participants ($n=32$) at the beginning of the programme was 4.68 (standard deviation [SD]: 1.92; range: 0–7). This meant that participants answered on average 4.6 questions correctly out of 7. Post-evaluation immediately after the last session, the knowledge had increased significantly and the mean was 7 or all participants answered all questions correctly. Overall, there was a positive perception of this approach, and the participants valued the confirmation of information acquired. The participants' ability to use the inhalers effectively was assessed using a practical demonstration. While some of the participants were nervous about the assessment, they valued it because it provided them with confirmation and reassurance that they were competent and that they would be able to demonstrate correct usage of the inhalers to other Travellers when they were required to do so.

Participants' knowledge of asthma following attendance

There was widespread agreement in all the focus groups that the participants' knowledge had improved over the course of the programme. There were four main areas in which this learning took place:

- Factors that exacerbated asthma or could cause an asthma attack.
- Knowledge of the inhalers and how to use them properly.
- Non-pharmacological approaches to managing asthma.
- The importance of follow-up and regular medical review.

Participants described having a greater knowledge and understanding of the causes of asthma and in particular the ‘triggers’ that could set off an asthma attack or worsen asthma generally. Throughout the transcripts, the participants talked about the inhalers in a more informed way and were able to describe not just how to use them but when to use them:

The other thing as well that we did learn is that the brown inhaler is a low dose steroid but the blue one is the one Travellers depend, they didn’t acknowledge [the value of] the brown one. (FG 2: Elaine)

There was also increased knowledge about the use of accessories such as the different types of spacers and the peak flow meter. In terms of non-pharmacological approaches to managing asthma, notwithstanding the triggers, the participants learned that controlling variables such as dust and smoke could help ease the symptoms of asthma as well as preventing an asthma attack:

Instead of wiping the windows down, damp dust them down so the dust doesn’t go everywhere. That helps. (FG 1: Mary)

Furthermore, there was a perception that participants could use this information to help other people who were having an asthma attack, something they might not have been able to do in the past:

For me, I thought I knew but I’d be inclined to panic if someone took a really acute asthma attack. Where now, I wouldn’t. I’d imagine I’d be better able to deal with it. (FG 1: Gemma)

Participants also spoke about the importance of the bi-annual medical review in terms of managing the symptoms of asthma, reviewing the diagnosis as well as reviewing the medication regimes that they were on. In addition, they talked about encouraging the families they visited, not just to visit the doctor but also to ask questions and seek clarifications about the treatments they were receiving if they weren’t sure about them.

Application of knowledge

It was clear from the transcripts that the participants started to apply the knowledge they learned almost immediately after the first session they attended. Application took place primarily within their own families where they used the information they learned to tell their relatives that they were managing asthma incorrectly or that they were not using the inhalers properly:

Yeah my niece is a very bad asthma and like I didn’t know, it was frightening really because what I found out from the training, I went back to her mother and from there then things is after improving for her. (FG 5: Pauline)

Similarly, in another focus group, one of the participants talked about how the information they had learned was transmitted almost immediately to people with asthma within the community:

Something that did happen which I think is a really big positive for the training. A number of individuals from the very first day had gone away and contacted family members or people they had known and those people went straight to their GPs and managed to get a further retest or referral. (FG 3: Liam)

Some participants spoke about their perceptions of what their role was in terms of being educated about asthma and then using this knowledge to teach other Community Health Workers within the Traveller community. In some community care areas, this process was underway and many of the participants described how they were in the process of educating other Community Health Workers who were in turn preparing to teach Traveller families about the management of asthma. Those participants who were in the process of teaching other health care workers about asthma spoke confidently about their ability to carry out this task and about how they have already started to deliver the programme in a manner that suited themselves without compromising the content:

A couple of us did the training with the Asthma Society and then bring it back to the 10 Eastern projects around the country. There wasn't room for everybody to do it, so we then deliver it back to the primary health care workers in our own area and then they will bring it out on the ground. That's the way it is. (FG 2: Betty)

Cultural preparation of facilitators and adaptation of teaching

In terms of design, a number of principles were adhered to when preparing for the delivery of the programme:

- There was an emphasis on making sure that each session was relatively short to maximise concentration levels and to make sure that not too much information was delivered during each session.
- Any teaching materials that were designed for use in the programme needed to use a combination of pictures and text with less emphasis on written materials.
- Any pictures that were used should reflect the Travelling Community and their lives and circumstances.

It was felt that regardless of literacy levels among the Traveller community, this approach was desired and generally better received than information that relied solely on the written word. Consultations with the Community Health Workers themselves informed the content of the programme and the teaching aids such as the information leaflet and poster underwent numerous refinements to ensure that they were culturally congruent. Although this process was time-consuming, there was a sense from the interviews with the stakeholders that it was essential if the programme was to be successful. The amount of work that was involved in the planning of the programme was perhaps underestimated and highlighted not just the difficulty of reaching disadvantaged groups such as the Traveller community but also the difficulties in ensuring that educational initiatives met their needs. However, the opportunity for the Community Health Workers to be involved in the design of the programme was perceived of as a positive component of the design phase as it gave them a sense of ownership of the programme:

And then we had an A3 poster, we had the pamphlet. They were all done, we scripted those and then Pavee Point put them into cultural language. We gave them the text and they put it forward to a working group of travelling people. As I said we gave them the script, and they, there was a lot of back and forth and then they had a lot of adding and subtracting so forth, then we put it all together and it was sent back again and it was sent off on. Weeks of work. First of all, it went through for cultural literacy through community

healthcare workers and the women's group. There were about 4 weeks of work there. And then the design, I got a designer in, we did it a mock up and it went back to [names people] to see if they agree. (Interview 1 with ASI stakeholder)

Prior to the delivery of the programme, the ASI educators completed 2 hours of cultural training which was facilitated by staff from Pavee Point. This training examined issues such as Traveller culture, language and communication; issues of dignity and respect and privacy. While this training was viewed in a positive light by educators, there was a sense that learning about Traveller culture and how to best meet their specific needs was experiential and developmental, and therefore, knowledge emerged as the pilot programme progressed. The wealth of knowledge that was accumulated through the process of planning, designing and subsequently implementing the programme was perceived as an unanticipated positive outcome from involvement in the initiative. The close relationships established with the participants who completed the pilot programme were also seen as a way for fostering a more positive image of Travellers and could be useful in gaining a better understanding of their culture generally. In the interviews with those who drove this initiative, there was a sense that there was a tendency to pigeonhole members of the Traveller community as illiterate. While this was the case in some instances, literacy levels varied among the Community Health Workers and the facilitators were sometimes surprised in some cases by the level of literacy and academic ability. Furthermore, where literacy levels were a concern, the Community Health Workers self-managed this themselves and were able to compensate for poorer reading and writing skills by working with more skilled individuals during the sessions:

One thing I was surprised how literate they were considering the message we had gotten beforehand. I must say, and we had to redesign the first day. When we had done the first day, level of literacy was different and maybe we undermined some of them. And didn't give them a choice, so the second day with our notes we had pictures and lines for them to write. (Interview 2 with ASI stakeholder)

Approaches known as 'energisers' were incorporated into some of the sessions. As their name suggests, these were brief activities they were used to increase energy and to help keep the participants alert. The importance of this was emphasised by the educational advisor from the Traveller community:

[The] Asthma Society didn't think the energisers were the best idea. But we insisted that it has to be done. And we had been saying this all along 'You have your own specialities, your area, you know that better. The same way we know travellers much better than you know so we know what is best for them'. (Interview with Pavee point stakeholder)

The participants described some of these approaches and talked about them in terms of games such as leaning back to back for support and doing counting and memory exercises. There was a mixed reaction to the use of these approaches – some of the participants did not like them at all and couldn't see their value, whereas others enjoyed them and felt that they were necessary to give the participants a boost when their energy levels were flagging a little. In addition, some of the participants enjoyed the activities and felt that they were a fun way to break up the sessions and that 'having a laugh' during the sessions was important for the group as a whole.

Discussion

Addressing cause-specific respiratory diseases among the Traveller community is a key recommendation of the All Ireland Traveller Health Study (Department of Health and Children, 2010).

The programme described here presents a viable alternative to the traditional health care education programmes which are often provider led and lack cultural sensitivity. High participation rates and active engagement from community members with the project and subsequent evaluation challenge the commonly held view of the community as 'hard to reach'. The community-based participatory approach that was used in the design and delivery of this programme ensured that cultural norms among the Traveller community were considered and used to inform the development of the programme. Francis (2010) has stressed the importance of cultural competence for health professionals, and the partnership approach utilised enabled the trainer to gain acceptance by this minority group. In addition, the partnership between the ASI and Pavee Point was instrumental in the delivery of the programme highlighting the necessity of programmes like these having an interface between 'technical' or 'expert' knowledge and the needs and desires of the community. Furthermore, the use of a train-the-trainer approach maximised capacity and utilised existing resources that have already proven successful in other areas. This is especially important within the Traveller community, which is traditionally described as a hard-to-reach population.

Capacity building

This cascade approach or train-the-trainer strategy has been shown to work and is an economical approach to building capacity and to outreach specialist asthma knowledge to Community Health Workers who may in turn disseminate that to other workers and families affected by asthma in the Traveller community. The educational process undertaken has impacted on participants' willingness to encourage Travellers to actively seek to reduce the effects of the disease. Findings reveal the considerable appetite among the Community Health Workers to improve the knowledge and care of asthma within their community.

Overall, in this asthma education project, capacity building was targeted at four levels identified by Crisp et al. (2000).

- *Bottom up.* The process created a dialogue and engagement with the Traveller community clarifying asthma health care needs and opportunities for capacity building.
- *Top down.* The organisational structure and philosophy of the primary health care projects enabled the process of development and provided the distribution network for implementation, thereby contributing to capacity building.
- *Partnership.* Stakeholder involvement throughout the project was evident at all stages in project, planning, development, implementation and evaluation. This positive experience will contribute to future capacity-building initiatives.
- *Community organisation.* The train-the-trainer approach has developed capacity within the community to actively respond and manage own health care needs around asthma.

The success of this initiative in removing a knowledge barrier is already in evidence. At the time of writing, it is estimated that the numbers of trained Community Health Workers now stands at 99 and that asthma education has been extended to approximately 500 families in those areas where it has been initiated.

Sustainability

While there is a desire for a national dissemination of the programme, a number of challenges exist that pose considerable barriers to its implementation. Most notably, these revolve around the availability of resources to deliver the programme on such a scale. Furthermore, the sustainability of the

asthma programme over time needs further exploration. This most likely will require a strategic alliance between ASI and the various PHCTPs located throughout the county. While capacity in the short term may be built by maximising the availability of the Community Health Workers and using the train-the-trainer approach, strategies will need to be in place to ensure that this is realised and that the asthma education is disseminated to its ultimate targets which are the Traveller individuals and families with asthma.

While in the short term the ASI have committed to providing support for the Community Health Workers who took part in the pilot programme, this is more of an informal arrangement. The Community Health Workers who completed the programme were confident of their ability to deliver the programme to its intended audience. However, during the focus groups, they talked about needing support to ensure that their knowledge about asthma remained current and this depended on some forms of educational follow-up. While the Community Health Workers felt that the ASI were in the best position to do this, there was a lack of clarity about how this follow-up might be provided or organised. This corresponds with Simmons et al.'s (2011) description of capacity building at a community organisation level as not being a single 'thing' but a collection of features and dimensions.

Equipping Community Health Workers with education and skills will go some way to increasing their agency within their specific community (Crisp et al., 2000). However, to achieve sustained change, active participation and engagement, supports for sustainability need to be conceptualised in tandem with educational initiatives. These strategies are especially important when planning health promotion activities with difficult-to-reach populations such as the Traveller community where uptake of activities already presents challenges.

Despite these uncertainties, a large volume of work has been completed, and if a national rollout was to occur, any future programmes would not require the same amount of planning and preparation. However, a national rollout would require a concerted effort to link in with all of the stakeholders throughout the country and be funded by the Health Service Executive using the train-the-trainer approach. Other health professionals such as clinical nurse specialists or advanced nurse practitioners with expertise in asthma could become involved in delivering the programme in central hubs nationwide in partnership with local Traveller organisations. This would mean that the Asthma Society and Pavee Point could retain a consultancy role and continue to be stakeholders in any subsequent developments. However, it is essential that the cultural congruency of the programme in how it has been designed for specific use with the Traveller community is not lost.

Limitations

The increase in participant knowledge may be overestimated due to the timing of the evaluation activity, immediately after the final education session. As with any qualitative study, there may be a bias as only those with very positive or very negative experiences may have volunteered to come forward for interview.

Conclusion and recommendations

The findings from this evaluation suggest that the pilot Asthma Education Programme had a positive impact on the participants, increasing their knowledge and skills about asthma. In addition, there is evidence to suggest that the participants were able to apply this knowledge and teach other Community Health Workers as well as Traveller families within their respective community care areas. Furthermore, the cultural congruency of the programme was welcomed by the participants. While some capacity-building strategies have been incorporated into the programme, there is a lack of

clarity about the sustainability of this initiative and how the Community Health Workers can remain engaged in the programme over time. In any future rollout of the Asthma Education Programme or similar programmes, both the sustainability of the programme and how this can be supported, need to be addressed in tandem with the design of the programme. In addition, strategies to evaluate the programme need to be considered, ensuring that the broad aims of the programme are achieved.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was funded by the Asthma Society of Ireland.

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