Methodological challenges of cross-language qualitative research with South Asian communities living in the UK

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Abstract

Objective

In this manuscript we investigate i) the influence of ethnic, gender and age concordance with interviewers and ii) how expression of qualitative data varies between interviews delivered in English and community languages (Punjabi/Urdu) with monolingual and bi-lingual participants, across three generations of the Indian Sikh and Pakistani Muslim communities, living in the United Kingdom (U.K.).

Methods

We analysed and interpreted semi-structured interview transcripts that were designed to collect data about lifestyles, disease management, community practices/beliefs, and social networks. First, qualitative content analysis was applied to transcripts. Second, a framework was applied as a guide to identify cross-language illustrations where responses varied in length, expression and depth.

Results

Participant responses differed by language and topic. First generation migrants when discussing religion, culture, or family practice were much more likely to use group or community narratives and give a greater length of response, indicating familiarity or importance to such issues. Ethnic and gender concordance generated greater rapport between researchers and participants centred on community values and practices.

Further, open-ended questions that were less direct were better suited for first generation migrants.

Conclusion

Community-based researchers need more time to complete interviews in second languages, acknowledge that narratives can be contextualised in both personal and community views, and re-frame questions that may lead to greater expression. Furthermore, we detail a number of recommendations with regard to validating the translation of interviews from community languages to English as well as measures for testing language proficiency.

Keywords

Ethnicity, community, concordance, language, South Asian, qualitative, interviews

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Introduction

Despite a greater propensity for living with chronic disease, people from minority-ethnic groups are underrepresented in applied health research[1-3]. Increasing participation remains a methodological concern as many from minority ethnic communities, living in developed countries, are excluded due to language needs[4,5]. Given increasing levels of global migration and the development of super-diverse cities[6,7] across the world, there is a need for qualitative research that is linguistically and culturally representative of study populations[8]. With regard to cross language research, greater attention has been placed on understanding the challenges of using interpreters and translators[9-11]. However, there is a trend towards the deployment of community based researchers. These are individuals embedded within the community of study, with the necessary language skills who have greater contextual knowledge and understanding of community beliefs/practices as well as social, personal and economic barriers to healthy living. Community based researchers are involved in the design, data collection and analysis stages of research projects, sharing their expertise on language, beliefs, values, and practices which could benefit the community involved[12].

Cortazzi et al.[13] outline a framework of practical considerations for monolingual and bilingual researchers to examine when including participants from diverse linguistic backgrounds into research. These include, but not limited to, recruiting interpreters/bilingual researchers, interviewing in either the researchers' or participant's first or second language or the participant uses their first and second

languages interchangeably. However, there have been some notable criticisms of using community based researchers. First, researchers cannot assume that minority-ethnic participants want to be interviewed by members of their own community, with some having a preference to discuss culturally sensitive issues with those outside of their community[14]. Second, languages are subject to dialectical and regional differences that can lead to certain words having multiple meanings depending on cultural context. Finally, priority is placed on matching researchers and participants on visual and/or explicit characteristics, for example race, religion, ethnicity and gender, with the belief that those who look the same speak the same[15]. Nevertheless, there are unpredictable ways in which race, religion, ethnicity and gender interact to produce narratives[16] and how participants may choose to conceptualise them[17].

For minority-ethnic researchers working with their 'own' communities, researcher identities are continually shifting between insider and outsider. Kusow[18] argues that the relationship between researcher and participant cannot be reduced to binary categories of status. Researcher identity is not simply shaped by the nature of the interaction, but the socio-political space within which the interaction occurs[18]. Ergun and Eredmir[15] strengthen this argument further, stating minority-ethnic researchers are not advocates of the communities they investigate. For example, communities reflect complex ideas of representativeness and may not wish to disclose information that could taint their identity[19].

People of South Asian descent make one of the largest minority groups living in the UK[20]; yet, vary by ethnic identity, religion, cultural practices and patterns of migration. We use Liu et al.[21] definition of South Asian i.e. a person with ancestry in countries of

the Indian subcontinent, including India, Pakistan, Bangladesh and Sri Lanka. For the purposes of this discussion we have avoided the use of generic terms, such as Black and Minority Ethnic (BME), which conflate issues of race and ethno-religious origin. Such terms can be problematic as they relate to a range of cultural and personal identities which may not be acceptable by all in a single community[22].

In the UK, Muslims from Pakistan and Sikhs from northern India (Punjab) form two of the largest diasporas outside of the subcontinent. Yet, both the Indian Sikh and Pakistani Muslim communities are under-researched in applied health research[23]. People of South Asian origin, and particularly men, have a higher risk of developing conditions such as diabetes mellitus (DM) and coronary heart disease (CHD)[24]. Often described as migrant populations, the composition of Pakistani Muslims and Indian Sikhs is changing with a growing number of second and third generation descendants. These groups, according to Ballard[25, 26], are constantly affiliating and adapting to multiple identities within various environments comprised of changing groups e.g. home, work, educational institutions.

Against this background of increased risk and underrepresentation we document the methodological challenges faced by two community based researchers interviewing Pakistani Muslim and Indian Sikh communities across three generations. We argue that concordance by gender, ethnicity and age along with language influence the nature of response given by monolingual migrants and bilingual second and third generation descendants. In doing so, we contribute to the literature that highlights the importance of understanding cross language research not simply as a product of concordance but an embodied and pluralistic practice.

Methods

Study design

Our study design was secondary analysis of qualitative interview transcripts from two community based research studies that explored perceptions of risk and/or living with cardiovascular diseases (CVD). A summary of both studies in presented in Table 1. Both studies were designed to investigate health beliefs and practices in Indian Sikh and Pakistani Muslim diasporas who are at greater risk of developing CVD related illnesses. Within this remit was the opportunity to address methodological challenges within the context of community based studies with minority groups. Within health services research, significant importance has been placed on researchers having a shared culture and experience with participants to develop a depth of understanding[27]. We acknowledged that research is not conducted in a vacuum and familiarity with cultural norms and values could increase participation[28]. With this in mind, we ensured that researchers shared a common background with participants and subsequently this meant we were unable to accommodate other South Asian communities e.g. Bangladeshi community. Secondary analysis was content driven focusing upon depth and detail of narratives opposed to critiquing structure of discourses. Albeit, both data sets recognised the importance of original meaning and contextualisation of words in community languages which have no direct translation in English.

Access and recruitment: Primary Dataset 1

Posters about the Indian Sikh study were displayed in general practitioner (GP) practices and attempts were made to arrange informal information sessions in places of worship. However, due to difficulties in working with places of worship, we used a

strategy of approaching gatekeepers with an established network of contacts. Written informed consent was taken immediately before the interview commenced.

Access and recruitment: Primary Dataset 2

Research advocates were contacted within minority-ethnic business districts to promote the Pakistani Muslim study via posters, word of mouth and disseminating information sheets. Third sector organisations and social media were also used to disseminate study details. Those who agreed were provided with additional information about the study. If they then agreed to participate, an arrangement was made for interviews and written informed consent was taken immediately before the interview commenced.

Sampling: Primary Dataset 1

A purposive sampling method via gatekeepers[29] with the aim of selecting individuals or family units comprised of first generation migrants and second and third generation descendants. At least one member of the family was diagnosed with a cardiovascular-related condition. We included men, women, and those aged 18 years or above. We selected a snowballing sampling method, where initial contacts would facilitate the identification of other, potential respondents.

Sampling: Primary Dataset 2

Similar to dataset 1, purposive sampling was used in tandem with snowballing methods to seek potential respondents. We included men, women, and those aged 18 years or above with or without an illness across three generations. Details of our sample are presented in Table 1.

Data collection: Primary Dataset 1

Semi-structured interviews (audio-taped in both English and Punjabi), translation and transcription were completed by MS. Interviews with first generation participants were completed in Punjabi. Translation was based on achieving conceptual equivalence i.e. importance was given to what was meant by the participant given the context of the conversation. Transcription (and hence translation) was conducted in English. Interview topics centred on lifestyle practices and the design and delivery of health promotion services for the management of long term conditions. Interviews were conducted in participant homes. Each audio recording and transcript was given a numerical identifier to ensure anonymity. Participants were informed that data would remain confidential within the research team. Ethical approval was obtained from South Birmingham Research Ethics Committee, UK.

Data collection: Primary Dataset 2

As with dataset 1, semi-structured interviews (audio-taped in both English and Urdu), translation and transcription were completed by FK. Discussions centred on barriers to healthy living, social networks, and generational differences in beliefs, values and practices to disease prevention. Interviews were conducted in participant's homes or at the University of Birmingham. Interviews were translated into English and transcribed by FK. Participants were informed of their right to withdraw from the study at any time and assured that their personal details would be kept confidential. Ethical approval was obtained from the University of Birmingham. All participants were given a numerical identifier to ensure anonymity.

Data Analysis

We used two stages of analysis. In the first stage, we adopted a qualitative content analysis approach to compare accounts on a similar range of topics separately for each study. Transcripts were descriptively coded by MS and FK, of which a sample was verified by members of the research team (NG, PG). Potential biases in data analysis (e.g. drawing conclusions heavily from a single participant from the sample) were resolved through monthly meetings with the research team for each respective study. Transcripts were coded with NVivo 10. Transcripts were re-read for methodological reflection, and that led to the second stage of analysis, identifying illustrations across both studies where language and the nature of the topic discussed influenced participant responses across three generations. Moreover, we investigated how the style of questioning altered depth of response from participants. MS and FK presented data regarding emerging themes from both datasets providing each collaborator the opportunity to ask questions and address analytical disagreements. We have used Cortazzi et al.[13] analytical approach, from a study of interviewing monolingual and bilingual Chinese participants, as a guide to interpreting and presenting our findings. Their intention was to elicit examples where researchers were insiders/outsiders, nuances of cultural communication, and where meaning may be unsaid but are applied.

Table 1. Description of studies and sample

	Primary Dataset 1- Indian Sikh Study	Primary Dataset 2-Pakistani Muslim Study
Research aim	To understand how members of a faith-based community interpret the risk of developing and/or living with a chronic disease (diabetes and cardiovascular disease), and what forms of self-care support they were accessing	To explore how social capital (social networks, trust and cultural norms) effects the prevention of cardiovascular disease within the Pakistani community.
Methods and content covered	Interviews were used with the aim of generating 'stories' covering a range of areas (healthy living, self-care, cultural practices, and religion) with the use of a topic guide.	Interviews were completed in order to collect data on social network structure, sources of support, information and influence on lifestyle factors pertaining to diet and exercise. A topic guide was used alongside the convoy model diagram to illicit responses.
Researcher background	MS is a qualitative researcher with a background in Sociology working in applied health research. As a male, second generation descendant of Sikh parents from the Punjab, India, he identifies with both a British and Sikh identity.	FK is a qualitative researcher with a background in Psychology, Health Psychology and Social Research. As a female, second generation descendant of Muslim, migrant parents from Pakistani she identifies herself with a British and Muslim identity.
Description of participants	Tri-generational families were recruited with one person living with diabetes and/or cardiovascular disease. The sample was comprised 17 participants of which nine were bi-lingual (English and	Tri-generational families were recruited across the West Midlands using word-of-mouth and snowballing techniques as well as lay-led posters and information sheets.

	Punjabi) and eight monolingual (Punjabi).	In total 42 participants (22 female, 20 male) were recruited from diverse occupational and educational backgrounds. Twelve participants were monolingual (Urdu) and thirty participants were bilingual (English and Urdu).
First generation (born in the subcontinent)	8	24
Age range	47-77	21-70
Male/Female	2/6	14/10
Occupation	Retired (4), Manual (4)	Retired (2), Manual (6), Housewife (4), Professional (9), Unemployed (2), Student (1)
Chronic diseases	Diabetes (Type 1 and Type 2), Hypertension	Hypertension
Second generation (born or received formal education from the age of five in the UK)	7	15
Age range	18-43	18-45
Male/Female	4/3	7/8
Occupation	Student (2), Manual (2), Professional (3)	Student (6), Manual (3), Professional (6)
Chronic diseases	Type 2 diabetes, Hypertension	None
Third generation (born in the UK and at least one parent is second generation descendent)	2	3
Age range	20-24	18-25
Male/Female	0/2	1/2
Occupation	Student (1), Professional (1)	Student (2), Professional (1)
Chronic diseases	None	None

Results

Language proficiency as a demonstration of authenticity

Although both researchers shared a number of similarities with first generation participants, there were key differences in linguistic communication, primarily an underdeveloped understanding of particular words and meanings in Urdu or Punjabi. There were words and meanings that were entrenched in concepts such as home, migration and an authentic identification of oneself as Punjabi Indian/Pakistani or Sikh/Muslim. Furthermore, migrant participant's command of their first language varied from unrefined colloquial dialect to those who were more educated. Regardless, first generation participants attempted to give direct conceptual and linguistic translations in English to help researchers to understand their accounts:

> 'What do you call it? Metabolism, in Punjabi we call it *Aagani,* so in some people their *Aagani* is much faster than what it is in others so it makes no difference to them.' (Male, First Generation, 52, Punjabi)

> 'I have been listening to some translations of the Quran, and it says in there that you have 2 or 3 *Nafs*, one is the good and bad one, do right or wrong… the other talks about eating (Female, First Generation, 48, Urdu)

Here the participant dictates the position the researcher has on the insider-outsider-researcher-participant spectrum. Albeit interviews were delivered in the participants' first languages, participants doubted the researcher's proficiency and subsequently provided greater explanation to their response. Here, first generation interviewees wanted to demonstrate their knowledge of both western and cultural/religious

concepts whilst simultaneously adopting a position of authority which warrants respect from the researcher to listen and acknowledge.

Concordance: ethnicity, gender and age

Interviews with participants across all three generations were influenced by ethnicity, age and gender, particularly in the context of marriage. A number of participants were of a similar age to our researchers (20-30 years) encountering social issues such as completing education, finding employment and suitable partners for marriage. There was an explicit assumption of a shared cultural knowledge about the practices of modern day "arranged introductions" for marriage and expected cultural conformity to participate in this tradition:

> 'I always had a really positive response which I think has surprised my family, and you know when they've said to people she's coming to age, she studied and all the rest of it, we'd like to start looking, nothing too serious lets just get the ball rolling, she's got to be married by the time she's thirty that kind of a thing (laughs)' (Female, Third Generation, 24, English)

The final phrase that concludes the excerpt 'that kind of thing', illustrates a shared experience between researcher and participant, where issues such as ethnicity, gender and age are acknowledged within a cultural space increasing rapport where the relationship becomes closer and personalised. Conversely, establishing a close relationship with participants is conflated with trustworthiness. In contrast to this shared parity of dialogue, first generation migrants took an informative stance where they felt comfortable commenting on the physical appearance of our female researcher:

> 'Yes, my daughter is as skinny as you are and I am always doing this to her – [grabs researcher's arm]- and she is skinnier than you are and she doesn't eat much and I was like that when I wasn't married, when [she] wears my clothes from before I was married its perfect how they fit her and I was skinny as well' (Female, First Generation, 46, Urdu)

> 'She'll [wife] have a long woolly jumper up to here [knee length] and her trousers, and you can't see anything of her. Just like you are dressed. I don't see anything wrong with it…' (Male, First Generation, 58, English)

Sharing a common caste identity became an essential prerequisite in understanding the context behind behaviours Sikh participant's practiced. Although Sikhism rejects the existence of caste, our male researcher shared the same caste identity (Jatt [agricultural background]) with 15 participants. This shared identity allowed participants to convey the importance of culturally embedded lifestyle choices, such as drinking alcohol, though religiously prohibited:

> 'us Jatts we don't let a person leave until they have fallen over and can't take anymore. This has always been the case, even people before us [previous generations] they were also like this, "pick it up, pick it up" [alcohol], these were the practices of Jatt people.' (Male, First Generation, 51, Punjabi)

Concordance by ethnicity, particularly having a South Asian background, defined the boundaries of the topic and the positions interviewees adopted. The nature of

relationships quickly moved away interviewer-participant to a familial nature such as 'mother-daughter' generating narratives entrenched in cultural practices passed from one generation to another. However, caution was taken not to assume knowledge of such traditions but for participants to present their narratives based on their own conceptualisations and experiences.

Cross-language illustrations

In order to interpret the nature of variation or similarity across transcripts, we used Cortazzi et al's[13] method of identifying examples where information was the same in both English and Punjabi/Urdu, there was greater divulgence or expression in English, and greater divulgence or expression in Punjabi/Urdu. We include both questions asked by interviewers (I) and responses given by interviewees (IV). In the following tables responses given in Punjabi (and correspondingly in English) are from the Indian, Sikh study and those in Urdu from the Pakistani, Muslim study.

Responses that showed little or no difference in English or Punjabi/Urdu

The following are examples where participants have conveyed similar information in English and in Punjabi or Urdu (Table 2). While, there are differences in the length of response there is little variation in content.

Table 2. Responses that showed little or no difference in English or Punjabi/Urdu

Question and response in Punjabi	***Question and response in English***
I: In your own opinion what would a healthy lifestyle be and what would a healthy person eat or behave? *IV: Firstly that person should have the right diet, and secondly if that person exercises that is also very good, because one should always control their diet, what they have to eat and drink. In my opinion if a person does these two things then that person can be healthy*	*I: Right, in your opinion what consists of a healthy lifestyle?* *IV: It's erm, positive mental health, its eating the right foods, exercise in moderation…and it's…yeah, that's it those three things really.*
Question and response in Urdu	***Question and response in English***
I: … so in your opinion what is a healthy routine? *IV: a healthy routine is eating properly and being observant of your diet and walking and going to the gym, that is a healthy routine but we don't do this.*	*I: yeah, so what in your opinion is like a healthy lifestyle?* *IV: um eating good, staying good, staying fit, staying healthy it's a nice lifestyle I don't think it's anything bad it's not slacking*

In both examples, information is almost identical: discussion centred on diet and exercise. There was a distinct variation in the manner in which questions were framed in English or Punjabi/Urdu, with questions asked in the latter taking much longer. This was a result of i) researcher's limited proficiency in community languages ii) translating questions accurately using terminology and concepts which may not exist in the English language (or vice versa) and iii) framing questions in respect of cultural, religious, and gender values to avoid causing offence.

Responses that showed greater divulgence and/or expression in English

The following are two examples (Table 3) where participants speaking English give greater personal biographical detail in their accounts. In the first example, the second generation participant addresses concerns regarding 'risk' due to a family history of chronic disease, generating a narrative centred on diagnosis and dealing with expectations. Narratives in English used more emotive language or phrases such as risk, hate, and positive. In addition, community based researcher confidently used their insider status whereby topics such as race were discussed without censorship. In contrary, topics such as diagnosis or family/friends may be considered too personal for first generation migrants to discuss with members of their own community, where researchers remain outsiders to their personal beliefs.

Table 3. Responses that showed greater divulgence and/or expression in English

Question and response in Punjabi	***Question and response in English***
I: I want you to go back to the start and tell me the time when you first were diagnosed with diabetes, tell me what happened? *IV: At first I had no illness then the doctor gave me some tablets and that caused my diabetes, that particular medication*	*I: How did you feel when you first diagnosed, what sort of thoughts were going through your head when they told you that you were diabetic?* *IV: Well I mean there was an element of…the back of your mind because you know you know that you have a family history and because of my dad I did some digging up on diabetes and those sort of things as well and then you realise and the you sort of have a medical check-up, I mean I've been having medical check-ups for a good few years and you do those through work anyway right and because you've been having those diabetes has always been recognised as a*

	risk so at the back of your mind you've been looking at that and that makes you half prepared it was still a bit of a shock and this and that and finally it's been diagnosed but it's probably a bit of a soft landing because in one way you've been expecting
Question and response in Urdu	***Question and response in English***
I: So do you think that your family or friends or people you know share this opinion [of health]? *IV: opinion, my child I will think that in my opinion, majority of our Pakistani people, they have the same opinion but I don't know, maybe some are tough and they don't care about anyone else but in my opinion you can't be inhumane and not look after your wife, kids and relatives, and if someone is ill then he will feel for it and when he feels it and if he is an old one so he will get to it*	*I: So what do you think people or your friends, have that kind of attitude towards health?* *IV: with my friends, at first I had a running buddy with me that was really big and then we kind of got her stamina really high and we did a couple of races and we were really good but then she put on the weight again and she said no I can't run any more, it's too much for me it's bad for my back so she stopped doing it and then you got, I've got white friends who stuck with me with running because they grew a passion for it then I've got the Asian girls who are getting married in a couple of months' time so they want to start running to lose it to get a flat stomach but it doesn't happen, you get tired, you might think I'm crazy but I get up at 8 to go running on a Sunday right, that's because you look forward to it, like I hate waking up, I know it sounds really bad but if I'm going swimming in the morning I look more forward to work, because yeah I'm going swimming in the morning and then I'm going to work and when I'm at work I'm finishing work and yeah I'm going for a good work out, I look forward to it because I have a positive relationship with working out because I know I would release those endorphins and get runners high*

Responses that showed greater divulgence and/or expression in Punjabi/Urdu

These examples (Table 4) show first generation interviewees speaking in Punjabi or Urdu spoke of their personal accounts but also how they would advise members of their own community with regard to healthy living. Here researcher and participant roles are clearly distinct; however, responses in English were much more generic rather than incorporating their own experiences to support their opinions.

Table 4. Responses that showed greater divulgence and/or expression in Punjabi/Urdu

Questions and response in Punjabi	***Questions and response in English***
I: In your thoughts whose responsibility is it to take care over one's health? *IV: Our own, other people shouldn't be responsible for you. If I tell your uncle that he is unwell he won't do anything about it, one has to do things for themselves. If one is able then they should look after themselves, once one falls then they cannot help themselves someone has to take care of them. When I was ill your uncle had to do everything for me because I was unable. I want to do things for myself; I don't believe in others, I don't like food that has been made by someone else. I want to be able to walk and do things for myself, being able to eat and feed myself.*	*I: What aspects of your health do you feel most responsible for?* *IV: Of my health…a bit of everything really you've got to be conscious of what you eat, my lifestyle, a bit of everything really you've got to look at what you want to eat, look at what you do, your sleeping patterns and things like that, a bit conscious of everything really not just one main area.*

Question and responses in Urdu	***Question and responses in English***
I: what would you say about your health right now? *IV: initially like I said when I left the army, the routine was disturbed and I put on some weight but since being x-army and having an army background I felt that it's not good being overweight and being unhealthy so I tried my best to go for physical activity but keep checking on my daily intake as well, whatever I have, that is even more important than your daily jogging*	*I: Mm. So what kind of… What would you say about your health right now?* *IV: It's okay. I dunno what I'd class it as. I wouldn't class myself as a healthy health type of person or a really unhealthy, just… Just normal, I'd, I'd say, but I'm not sure.*

The presence of bilingualism

The extent to which participants changed from speaking one language to another was limited to second and third generation bi-lingual participants, with only occasional references made by first generation participants to particular foods or concepts i.e. 'sugar' (diabetes). Bi-lingual responses (Table 5) referred to accounts regarding religion, culture, and caste. There was distinct lack of bilingualism on topics such as exercise, dietary behaviour, and illness. Allowing for bi-lingual accounts, however fraught, increases the credibility of participant narratives; using the most accurate terms to describe their experiences, rather than relying on terminology which they feel the researcher, or a wider audience, would be able to understand.

Table 5. The presence of bilingualism

Response in Punjabi or Urdu	***Response in English***
*IV: I don't know, but I think there is an organ within the body that stops making **sugar**. Some people say it is with eating **sugar**, it can't be with eating **sugar** can it?* *IV: well praise be to Allah, my mum and mother in law I saw that they had **blood pressure** and **sugar** and heart problems till now I don't have that*	*IV: It's conformity isn't it, it's what other people would perceive to good **seva** [selfless service] for them and you don't want to disrespect anyone that comes around, well that's what you're brought up with and it's something that you internalise and you don't challenge the status quo because the last thing, over any food or health is you don't want people to walk away with a bad taste in their mouth about the way you've treated them when they've come to your house you know, so it's not a battle worth having* *IV: yeah, communities so you've got your dads community like you say **beradri** [kinship], like we've got my dads who are from the village in Pakistan and then we've got my mums who are quite lenient cause they're from the city but that's like a contradiction within itself, then you've got the whole British thing and you go to work and there's only three brown people who work with you so, you're pulled in all directions and you've got a passion for something and all the Muslim girls that want to do it are like oh you run, so it must be fine obviously its doing good for you but do you think its Islamic, its like I don't know I'm not a **molvi** [religious clerk] I don't know so like just get on with it you're going to die soon anyway (both laugh) its true though! Although, isn't it?*

However, given the presence of bilingualism was reduced to topics of religious or cultural significance, the advantage was the ability of researchers to draw on such shared knowledge probing the participant further. Using researchers from the community lead to greater nuanced data that leads to greater exploration. Hence, if participants have greater awareness of the availability of community based researchers

who can better understand their narratives this may lead to greater participation from minority groups in applied health research.

Discussion

The nature of accounts with Indian Sikh and Pakistani Muslim communities differs according to language and topic. First generation migrants when discussing religion, culture, or family practice were much more likely to use group or community narratives and give a greater length of response, indicating greater familiarity or importance to such issues.

Our findings show the importance of a household approach to researching minority ethnic communities as well as the role of interlanguages (i.e. the language system a learner of a language constructs out of the linguistic input that he or she has been exposed to)[30]. Hence, participants shifted between second and first languages to construct their narratives with bilingual participants placing themselves at the centre of their socially contextualised accounts emitting a strong individualistic identity. These differences may be a result of the socio-economic progress and acculturation of second/third generation descendants compared to first generation migrants. For instance, accounts were entrenched in 'personal development' with regard to healthy living; hence, not adhering to shared community values and norms on diet, cooking practices and exercise.

Notably, how findings highlight qualitative data collection with minority-ethnic communities needs revisiting. Temple and Young[10] discuss the importance of agreement at the source (i.e. the participant), with regard to accuracy of translation, to

remove any potential bias. Moreover, 'racial matching' of interviewers and participants can be problematic where the researcher/translator role is dictated by the social positioning in their community of interest[31].

Interviews are not culturally neutral despite South Asian participants having a greater preference for talk-based methods. The employment of bilingual researchers, by promoting a shared language and cultural background, allow for the possibility of using a sharing stories approach to elicit data that is contextually relevant to understanding beliefs and practices. Hence, community based bilingual researchers become producers of research data and shape analysis through their identity and experiences as well as those of participants[32]. As a result, we propose the following recommendations when collecting 'talk-based data' from minority ethnic groups using bilingual community researchers:

1. First, second and third generation individuals from minority-ethnic communities should be given the opportunity to be interviewed in their first and second language

2. The language proficiency of bilingual researchers should be tested/measured for linguistic ability

3. Throughout interviews, researchers need to address concerns of conceptual equivalence in order to comprehend the meaning of interviewee narratives

4. If feasible, interviews conducted in minority-languages and transcribed in English need to be checked for conceptual equivalence by an external member of the research team

5. Talk-based data collection methods used with minority-populations need to allow a greater length of time, for example when translating and framing questions during interviews

Community based researchers bring a range of skills and knowledge within qualitative health research that are difficult to replicate with interpreters or link workers used in previous studies[32]. Community researchers bring knowledge of how to recruit, interview and interpret data from minority ethnic communities, and the closeness of the relationship that can be developed with interviewees can increase the likelihood of participation in applied health research. In addition, research methods, such as interviewing, are not culturally neutral, with the question and answer style alien to many minority-ethnic communities[34]. Ultimately, researchers need to be flexible in their interview style to incorporate the interwoven social, cultural and religious nuances in participant narratives and generate findings as a single perspective.

The strengths of our study are the number and varied background of participants recruited from two 'at risk' minority ethnic communities. We have included a range of examples to highlight how concordance and language can influence the presentation of narratives. Our findings may be transferable to other 'at risk' communities living in developed countries. Methodologically, we have contributed to existing literature by identifying that certain cultural, social, and religious concepts/discussions could happen

with more nuance and depth in community languages and others in English. Such a method of analytical interpretation could be further added to and developed in future studies with minority groups.

However, including members from minority ethnic communities from other parts of the world and not just the subcontinent may have highlighted different topics that could alter the depth and expression of response in English and other languages. We have only focused on using interviews to collect data, where community based researchers using other methods (e.g. observation) may encounter different outcomes. Our sample size is small and our findings may be transferable to but not generisable to other minority communities. The nature of topics addressed throughout interviews may have influenced the depth, detail, and diversity of narratives developed between researcher and participants. Our findings may be different if transcripts were not translated into English and then subsequently coded, as importance was placed on conceptual and not linguistic or structural equivalence.

Conclusion

The recruitment of community based researchers plays an important role when attempting to recruit participants from marginalised groups. Further methodological research needs to explore how the researcher/translator epistemological position influences insider/outsider status, whether the order and frequency of interviews with mono/bi-lingual participants influences the nature of emergent themes, and the consequence of end of interview clarification with participants relating to the meanings of words and/or concepts. This article strengthens the argument for adapting existing talk-based data collection methods, re-considering the current format of how to ask

questions and interpret exchanges throughout qualitative interviews. Acknowledging the presence of different narratives can lead to nuanced analysis of participant accounts in second languages, which may lead to a better understanding of the health needs of minority groups living in developed countries.

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Conflicts of interests

The authors declare that they have no conflicts of interests.

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