Briefing Report: “My Health Matters”

A community-led intervention aimed at reducing health inequalities related to physical activity and healthy eating

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BRIEFING REPORT

"My Health Matters"

A community-led intervention to reduce health inequalities related to physical activity and healthy eating

Background

There is growing recognition that the rising incidence of obesity is being driven by environmental factors that affect individuals' physical activity and dietary choices.

The environments and neighbourhoods in which we live, and with which we interact, have become ones that encourage lifestyle choices that decrease physical activity and encourage over consumption of foodstuffs. Recent research related to obesity has signalled a simple, evolutionary shift away from individually orientated theories to broader, more environmentally based approaches for understanding and altering the wider environmental and social determinants of health behaviours.

There is a strong link between the built environment, health outcomes and inequalities in health. Elements of the built environment can negatively impact on levels of physical activity and dietary behaviour [1, 2].

The "My Health Matters" project was designed specifically to help build partnerships with statutory healthcare providers and the local voluntary and community sector to help meet the challenge of increasing physical activity levels and healthy eating in targeted areas in Stoke-on-Trent.

The project is based on evidence that increasing levels of physical activity and healthy eating will help to improve life expectancy in Stoke-on-Trent, which is 2.4 and 2.1 years below the national average for males and females, respectively [3]. It acknowledges that the voluntary and community sector are best placed to reach the often 'unseen' and 'unheard' people in our communities to promote the desire and motivation for lifestyle change.

Underpinning Approaches

The project design and implementation have been based on a number of models or approaches. A ***Community Development*** approach to health improvement is informed by the social determinants of health model and seeks to tackle the root causes of ill-health, including poverty, unemployment, educational disadvantage, social isolation and poor living conditions. The community development process enables people to organise and work together to: identify their own needs and aspirations; take action to exert influence on the decisions which affect their lives; improve the quality of their own lives, the communities in which they live, and societies of which they are a part.

This is linked to the ***asset-based approach*** which values the capacity, skills, knowledge, connections and potential within a

community. Assets can be described as the collective resources, which individuals and communities have at their disposal, which protect against negative health outcomes and promote health [4, 5].

Community-based participatory research is an increasingly popular method of addressing health and well-being in a community. It is defined as a collaborative approach to research that equitably involves those affected by the issue under study for purposes of gaining knowledge or understanding about a practical community issue and taking action to effect change [6]. Central to this is ***community capacity building*** and ***community empowerment*** in encouraging individuals to take responsibility for their own health [7].

The My Health Matters project is based on the ***socio-ecological model*** which conceptualises health broadly and focuses on multiple factors that might influence health. The model understands health to be affected by the interaction between the individual, the group/community, and the physical, social, and political environments [8]. Both the ***community engagement approach*** and the ***socio-ecological model*** recognise the complex role played by context in the development of health problems as well as in the success or failure of attempts to address these problems. This model can be used to identify factors at different levels (individual, interpersonal, organisational, community and public policy) that contribute to poor health and to develop approaches to disease prevention and health promotion that include action at those levels. This model focuses on integrating approaches to change the physical and social environments rather than modifying individual health behaviours alone. A recent paper in the Lancet supports a systems approach to physical activity beyond a reliance on behavioural science which needs coordinated changes at the individual, social and cultural, environmental, and policy levels [9].

This approach is also supported by recommendations from the Marmot Review that effective local delivery requires effective participatory decision-making at the local level which can only happen by empowering individuals and local communities. Further guidance from the Marmot Review includes advice to move beyond routine, brief consultation to create opportunities for communities to define local problems, find local solutions and set the agenda for change [10].

The "My Health Matters" Project

The project aimed to develop and evaluate a community-led intervention to reduce health inequalities by increasing physical and promoting healthier eating as defined by community members themselves. The project focused on three deprived wards in Stoke-on-Trent (Burslem South, Weston and Meir North and Bentilee and Townsend), all of which are in the bottom 40% of the national deprivation rankings [11] and recently identified as social exclusion hotspot areas in Stoke-on-Trent [12]. The project was conducted in four phases over a three-year period between June 2009 and March 2012; some phases were ongoing and completed concurrently.

Phase I: Produce a detailed baseline map of the built environment in each of the three wards using Geographical Information Systems (GIS) at the level of Lower Super Output Area and integrate this with information obtained from a community postal survey.

Phase II: Develop effective partnerships between Staffordshire University, key professional stakeholders in health and the community to design neighbourhood

interventions and engage local residents to strengthen community involvement.

Phase III: Based on partnership consensus, identify, prioritise and design pragmatic intervention(s) that address specific environmental disparities related to physical inactivity and healthy eating.

Phase IV: Pilot the intervention(s) in order to test process, implementation and effects of this approach on physical activity and healthy eating behaviour.

Specific outcome measures were chosen and measured during this study, including: changes in local population levels of self-reported physical activity, fruit and vegetable consumption, social capital and general health status.

This briefing report presents key findings from the implementation and evaluation of the My Health Matters (MHM) project.

Evaluation Design

A case-study, pre-post intervention design was used to evaluate the programme, comprising four parts:

a) ***Geographical Information Systems (GIS) mapping*** of selected residential addresses (n=4,787) measuring: proximity of physical activity (PA) spaces and places; neighbourhood connectivity and walkability; land-use-mix; population density; traffic, safety and crime; and food outlets.

These measures described aspects of the environment that can either have a positive or negative influence on health behaviours (e.g. PA) and health outcomes. All GIS measures were calculated around every residential address within the targeted study areas.

b) A postal ***community survey*** of randomly selected addresses across the three target areas was undertaken pre- and post-intervention. The survey measured socio-demographic information; perceptions of environmental characteristics relating to physical activity (Neighbourhood Environment Walkability Scale-Abbreviated) [13]; perceived health status (SF12v2) [14]; social capital (e.g., trust, reciprocity and perceptions of anti-social behavior and crime) [15]; fruit and vegetable consumption as a proxy measure of healthy eating; Body Mass Index (BMI); and physical activity (International Physical Activity Questionnaire, IPAQ) [16]. All questionnaires have been validated and used extensively in previous research.

c) ***Project Monitoring.*** To evaluate the processes involved in the development and implementation of community-led interventions, there was continual monitoring of programme activities and associated outcomes. Participants who engaged in the project were required to complete the My Health Matters questionnaire, which established baseline levels of physical activity, and healthy eating behaviour and intentions. A sub-sample of individuals was randomly selected to take part in follow-up telephone interviews at six months post initial participation, to assess change in physical activity and healthy eating behaviour. A database was set up to record community issues and subsequent action taken to address them.

d) A ***qualitative process evaluation*** of the development and implementation of specific community interventions, and of community members' experiences of the MHM project was undertaken. This involved conducting interviews and focus groups with residents, partner agencies and project community

champions. Interviews and focus groups were analysed using Thematic Analysis [17].

Implementation

The My Health Matters project was facilitated by three, area-based, Community Development Workers (CDW's) employed by Changes (a charity organisation). This project was implemented according to Phases I – IV previously mentioned.

Phase I produced a neighbourhood profile of each targeted area. This not only provided baseline statistical information for assessing change at follow-up, but gave an objective and subjective spatial picture of the current local situation.

In general the environments of all three areas were not supportive of healthy living, did not facilitate physical activity or help to promote healthy eating. There was a lack of local access to fresh food outlets and an abundance of fast food outlets. A large number of residents lived within 300m walking distance of large areas of green space, but these spaces were often of poor quality (e.g., poorly maintained, no facilities on them, not functional or properly maintained/managed). Access to physical activity facilities within walking distance was variable across and within each of the three areas.

In addition, self-reported general health was lower than the national average and residents surveyed in each of the areas were not eating the recommended daily amount of fruit and vegetables. Approximately 80% of those surveyed were sedentary and not reaching the recommended 150 minutes of moderate intensity activity per week [18].

In relation to social capital, most survey respondents enjoyed living in their area with individuals, on average, living in their neighbourhood for over 20 years. However, across all three areas, there was low perception of trust of others and perceptions of problems with teenagers and vandalism. One-third of respondents, did, however, take part in groups or organisations (e.g. church groups, social clubs).

A number of positive environmental characteristics were identified, including land use mix (access and diversity of local amenities/services) and infrastructure and safety for walking (e.g., pavements, paths, road connectivity). On the other hand, aesthetics (e.g. lack of trees, attractive areas to walk), traffic hazards (e.g. volume, speed and traffic accidents) and crime were identified as negative characteristics relating to the walkability of the areas.

Information collected during Phase I was used to inform community consultation and action (Phase II-III). Results demonstrated a need to take a transformative approach, led by the community, to develop local area programmes to address specific issues in each targeted area.

Recommendations from Phase I

- Raise the profile of the "My Health Matters" project and actively engage key community members in project development and implementation.
- Offer training opportunities for local residents/volunteers in community consultation, design and delivery of identified interventions.
- Develop areas of local green space improving quality, functionality and implement low cost interventions that reach a large number of the target populations.
- Identify green spaces that can be used for community gardens/allotments.
- Explore opportunities for community collectives and social enterprise around local

"mobile markets" for fresh fruit and vegetables.

• Optimise use of local physical activity facilities by providing appropriate activities, advertising widely and utilising church halls, community venues, libraries, school facilities (out of school time and in school holidays).

• Raise levels of awareness of existing physical activity classes/groups running in the area and develop capacity to increase the number and range of activities provided.

• Local supervision: target crime prevention and street security – community policing and increase opportunities for organised Youth Activities/Groups.

Phase II of the project focused on: raising the project profile in each of the targeted areas using various strategies; developing partnerships will local health service providers; identifying and establishing community groups for intervention planning; and assessing the needs and priorities of each study area through community consultation using participatory appraisal methods.

A sustained period of promotion was undertaken at the start of the project to establish a presence within the local community. Project promotion continued throughout each phase of the programme and provided the basis for engaging community members, and recruiting volunteers and project partners. My Health Matters CDWs sought to engage with existing community groups and develop new groups within each study area. To facilitate this process a number of activities, which were classified as ***opportunities*** for engagement, were delivered, such as:

- Delivery of MHM community and partner agency events; e.g., picnic in the park and listening events.
- Health promotion and awareness activities; e.g., health stands at events, facilitation of health talks to community groups, delivery of community health checks and signposting to other services.

Phase I of My Health Matters implementation produced a picture of the current situation using GIS and a cross-sectional community survey. It was essential to compare this information with the experiences of local residents. Individuals are experts in their own lives and, therefore, their thoughts and opinions must be captured, valued and used to inform collaborative action. This aligns to the identification of assets, such as capacity, skills, knowledge, connections, and potential within a community.

Extensive community consultation was undertaken with existing and newly created community groups in order to identify community assets, challenges and priorities for change. This was done using participatory appraisal techniques and geographical information systems for participation (GIS-P) which aligns to the 'bottom-up', community-led ethos of the project.

Examples of community challenges identified through community consultation;

Health

• Poor levels of health in each study area.
• Health not being a priority and local residents not seeking health advice until a health problem arises (reactive, not preventive).
• Some residents not registered with health services, e.g. GPs, dentists.

Physical Activity Facilities

• Existing facilities not appealing or sufficiently inclusive to residents.
• Existing facilities too expensive or inaccessible due to opening times or a lack of transport to get to them.

• Community facilities – under-resourced and under-used.

Food Access

• Locally available fruit and vegetables too expensive; lack of variety and often of poor quality.
• Easy access to fast food take-aways with new outlets being opened.
• Lack of competition driving up cost of fresh fruit and vegetables.

Service Provision

• Residents don't believe that 'anything gets done'.
• Lack of youth provision (11-19yrs).
• More family activities in local facilities needed.

Lack of Awareness, Information and Knowledge

• Lack of knowledge of existing activities and services ('nothing going on in the area').
• Lack of knowledge relating how to cook fresh fruit and vegetables.

Environment

• Poor quality of some local parks and play areas (not well maintained).
• No facilities within local green space e.g. bathroom facilities or benches (barriers to older people).
• Poorly lit alleyways and walkways.

Crime and Anti-Social Behaviour

• Perceptions of 'gangs of youths' hanging around the streets as they 'have nothing to do'.

Isolation and Lack of Cohesion

• Feelings of abandonment, being let down and a lack of trust, especially in regeneration areas.
• Lack of cohesion between long-standing residents and short term rental tenants.
• Some existing groups can be too protective and possessive of facilities.

Funding

• Some groups lack knowledge of potential funding streams and confidence in applying for them.
• Some desire from residents to develop groups and activities but face barriers in funding for required training, e.g., food hygiene certificate, music license.

During this phase each area also developed a local 'health forum', which aimed to bring together the community and health service providers. These forums provided the vehicle for collaborative, multi-agency working in identifying priorities for and supporting change. The forums are managed by its members and facilitated by the My Health Matters Team.

Triangulation between phase I (community profiles developed through GIS mapping and a community survey) and phase II (information collected through community consultation) was conducted in order to inform phase III of the programme. This ensured that Phases III and IV were grounded in community assets, challenges and the potential influencing factors related to behaviour change.

Phase III and IV focused on intervention development and implementation. The exact mix of intervention activities in each area was based on priorities identified by residents and the facilities and services (or *assets*) within the area. Intervention activities can be broken down into the following areas: physical activity; healthy eating; health promotion; education and awareness; well-being; and environment-related and gardening activities. They were delivered in partnership with local community, voluntary and health sector organisations, such as residents associations, children's centers and community groups.

Examples of intervention activities delivered in each area include;

Intervention Activities

Bentilee and Townsend

• The ***St. Maria Goretti Garden Project*** is an after school club aimed to encourage children to grow their own fruit and vegetables. The produce grown is then used in cook and eat education sessions at the school. The pupils are also encouraged to take fruit and vegetables home to their family.

• The ***Lite for Life Healthy Lifestyle Community Project*** aimed to develop physical activity opportunities within the area of Townsend as defined by community members themselves, this included the delivery of gentle exercise, zumba, 'hips, bums and tums' and yoga classes delivered by a qualified instructor in community locations for an affordable price.

• ***Moss Green Community Health and Well-Being Group*** developed a programme of activities aimed at improving health and well-being of members. It emphasises use of existing skills and experiences of group members and is supported by the MHM.

• ***Treehouse Children's Centre*** supported the development and delivery of healthy eating, physical activity and gardening activities (e.g., *Family Food and Getting Active Project; Young Gardeners Project).*

•***Green and Grow Project Townsend:*** a community 'grow your own' project.

•***Real Time Community Change Project*** facilitates the distribution of a local councilors ward budget to community members using a bottom-up, community-led approach.

• The ***Townsend Coffee and Craft Social Group*** encouraged families to decrease waste, re-use and recycle with the aim of reducing the amount spent on household items whilst gaining skills and sharing knowledge.

Burslem South

•***Picnic in the Park*** is an annual event organised by My Health Matters. Each year it centres on a theme, such as the Football World Cup and the event aims to highlight Burslem Park and promote physical activity, healthy eating and social cohesion within the local community.

• The ***Portland Street Community Centre*** has developed into a central hub of the local community. A large number of MHM events and regular activities are delivered in this community asset, e.g. ladies only zumba classes, breakfast clubs, cook and eat sessions.

• ***ROC Café Youth Club*** and MHM have worked in partnership with SPORTED to fund weekly sports sessions over a three year period with progression routes for young people wanting to get involved in sports coaching. The project is called ***ROC Sport.***

• ***'Let's get Cooking'*** is delivered by a MHM community champion who was funded to undertake the let's get cooking demonstrator course (NHS Stoke-on-Trent). Each 'let's get cooking' course consists of six, two hour long sessions, which provides participants with the opportunity to learn or improve their basic kitchen skills and learn how to cook and prepare healthy meals.

•***Community Cohesion cook-along sessions,*** delivered at St. John's Church, were designed to promote intergenerational cohesion. Older people in the community have a wealth of skills and information that was passed on to the younger generation.

Meir North

• The ***Crescent Children's Centre Allotment Project*** is led by a MHM community champion and supported by local volunteers.

The allotment project has developed into a small enterprise; the produce grown on site is sold to families visiting the children's centre. A partnership has also been made with the local primary and secondary schools, providing pupils with practical skills and knowledge to grow their own fruit and vegetables.

• '***The Friendship' group*** at the Square has developed a programme of health and well-being activities including; yoga, cheerleading circuit training, community fun days, a healthy eating luncheon club and grow your own fruit and vegetables.

• ***Cook and eat sessions*** delivered at various community locations, such as, The Yard, Rowan Village (retirement village), Shelton day care centre etc.

• Supporting adults with learning disabilities to address issues concerning health and wellbeing through partnership working with ***ABLE*** (Person**A**l Well**B**eing, Hea**L**th and Saf**E**ty in vulnerable groups).

Key Findings

The following section summarises key evaluation findings.

a) GIS Mapping

The GIS mapping highlighted the positive and negative trends observed where pre- and post intervention data were available. The results focus on: access to shops and food outlets; access to PA facilities; road traffic accidents and reported crime and anti-social behavior.

The majority of findings present positive trends across all three areas. All demonstrated an increase in access to PA facilities / opportunities and an increased availability of fresh food retail. All areas showed a reduction in anti-social behavior incidents and reduced levels of reported crime for the majority of sub-categories. Road traffic casualties also reduced for the majority of sub-categories.

Where negative trends were evident, there were often compensatory positive trends. For example, in Meir North and Burslem South there was a small increase in the average number of fast food outlets available, but a concurrent and proportionally larger increase in the average number of Fresh Food outlets or opportunities.

The key trends are reported for each ward in Tables 1-3.

Table 1. Summary of GIS findings for Bentilee and Townsend

Bentilee and Townsend (2,835 mapped addresses)
Positive trends in;
• Access to PA facilities within 500m and 1km • Number of reported violent crime and burglary within 1km • Reported anti-social behavior incidents within 1km • Overall, average number of road traffic accidents and casualties within 1km, • Average number of road traffic accidents and casualties involving cyclists within 1km • Increased average number of food retail outlets within 500m and 1km • Decreased average number of fast food outlets within 500m and 1km • Increased average number of fresh food outlets within 500m and 1km
Negative trends in;
• Average number of road traffic accidents and casualties involving cars within 1km • Average number of road traffic accidents and casualties involving pedestrians within 1km

Table 2. Summary of GIS findings for Burslem South

Burslem South (1,132 mapped addresses)
Positive trends in;
• Access to PA facilities with 500m and 1km • Number of reported violent crime within 1km • Reported anti-social behavior incidents within 1km • Number of road traffic accidents and casualties, including pedestrians and cyclists within 1km • Increased average number of fresh food outlets with 500m and 1km
Negative trends in;
• Number of reported burglary incidents within 1km • Decreased average number of food retail outlets within 500m and 1km • Increased average number of fast food outlets within 500m and 1km

Table 3. Summary of GIS findings for Meir North

Meir North (820 mapped addresses)
Positive trends in;
• Access to PA facilities within 500m and 1km • Number of reported violent crime and burglary within 1km • Reported anti-social behavior incidents within 1km • Number of road traffic accidents and casualties, including pedestrians and cyclists within 1km • Increased average number of food retail outlets within 500m and 1km • Increased average number of fresh food outlets within 500m and 1km
Negative trends in;
• Increased average number of fast food outlets within 500m and 1km

b) Community Survey

The community postal (cross-sectional) survey yielded a response rate of 12.3% (n=343) at baseline and 13.5% (n=375) at follow-up. Despite a low response, respondents were representative of the study population in terms of gender, socio-economic status and ethnicity. Table 4 provides an overall summary of cross-sectional survey results from baseline to follow-up.

Table 4. Summary of cross-sectional survey findings from baseline to follow-up (all wards)

Cross-sectional Sample (Baseline n = 343; Follow-up n = 375)
Statistically significant (α-level *.05, **.001), positive changes in;
• Self-report physical activity* • Neighbourhood perceptions of crime** • Social capital; perceptions of anti-social behaviour (inc. problems with teenagers and vandalism)** • Perceptions of traffic hazards*
Non-significant, but positive trends in;
• Perceived health status (SF12v2, Physical and Mental Component Score; PCS, MCS) • Fruit and vegetable consumption • Social capital; enjoyment of living in the area, access to services, and participation
Statistically significant (α-level *.05, **.001), negative changes in;
• Perceptions of a lack of parking (barrier to walkability)*
Non-significant, but negative trends in;
• Perceptions relating to land-use-mix (barrier to walkability) • Social capital; trust and reciprocity

Tables 5, 6 and 7 present area-based summaries of cross-sectional survey results from baseline to follow-up.

Table 5. Summary of Bentilee and Townsend cross-sectional survey findings from baseline to follow-up

Bentilee and Townsend (Baseline n=150; Follow-up n=154)
Domain, direction of change and significance **(Significant = α-level .05*, .001**, Non-significant=NS)**
Positive changes in;
• Self-reported health (SF12v2) (NS)
• Neighbourhood perceptions of; land-use-mix (access , diversity), infrastructure and safety for walking, aesthetics and physical barriers (as barriers to walkability) (NS)
• Neighbourhood perceptions of; traffic hazards* and crime*
• Fruit and vegetable consumption (NS)
• Perceptions of anti-social behaviour (inc. problems with teenagers and vandalism) (NS)
• Perceptions of access to services and participation in groups (social capital) (NS)
Negative changes in;
• Neighbourhood perceptions of cul-de-sacs and a lack of parking (as barriers to walkability) (NS)
• Negative changes in perceptions of trust and reciprocity (social capital) (NS)

Table 6. Summary of Burslem South cross-sectional survey findings from baseline to follow-up

Burslem South (Baseline n=115; Follow-up n=131)
Domain, direction of change and significance **(Significant = α-level .05*, .001**, Non-significant=NS)**
Positive changes in;
• Self-reported health – Mental Component Score (MCS; SF12v2) (NS)
• Neighbourhood perceptions of; land-use-mix (access), street connectivity, infrastructure and safety for walking, aesthetics and cul-de-sacs (as barriers to walkability) (NS)
• Neighbourhood perceptions of crime*
• Fruit and vegetable consumption (NS)
• Perceptions of anti-social behaviour (inc. problems with teenagers and vandalism)**
• Perceptions of access* to services and participation in groups (NS)
Negative changes in;
• Self-reported health – Physical Component Score (PCS; SF12v2) (NS)
• Neighbourhood perceptions of land-use-mix (diversity), parking and traffic hazards (NS)
• Negative changes in perceptions of trust and reciprocity (social capital) (NS)

Table 7. Summary of Meir North cross-sectional survey findings from baseline to follow-up

Meir North (Baseline n=78; Follow-up n=90)
Domain, direction of change and significance **(Significant = α-level .05*, .001**, Non-significant=NS)**
Positive changes in;
• Self-reported health – Physical Component Score (PCS; SF12v2) (NS)
• Neighbourhood perceptions of; street connectivity, aesthetics, parking, cul-de-sacs, crime, hilliness and physical barriers (NS)
• Neighbourhood perceptions of traffic hazards*
• Fruit and vegetable consumption (NS)
• Perceptions of anti-social behaviour (inc. problems with teenagers and vandalism) (social capital)*
• Perceptions of trust and reciprocity and participation in groups (social capital) (NS)
Negative changes in;
• Neighbourhood perceptions of land-use-mix (access, diversity) (NS)
• Perception of access to services (social capital)*

c) Project Monitoring and Outcomes

Individuals could engage with the My Health Matters project in a number of ways and with differing levels of involvement. Over the three years of the My Health Matters project (June 2009 - March 2012), ***11,525 contacts*** were recorded, including all face-to-face contacts with community members, such as:

- MHM community and partner agency events (e.g., picnic in the park, listening events).
- Health promotion activities (e.g., health stands at events, facilitation of health talks to community groups, delivery of health checks).
- Health awareness events (e.g., drop-in sessions, coffee mornings).
- Community consultation activities.

This figure presents counts of attendances, rather than individuals, so multiple attendances by the same individuals cannot be discounted. However, it is likely to be a conservative estimate as it was not feasible to count attendance for some activities.

During the three years of the project ***1,678 individuals were engaged*** in intervention activities, such as:

- Regular physical activity sessions (e.g., zumba, hips bums and tums, yoga).
- Regular gardening and allotment clubs / sessions.
- Regular healthy eating education workshops and cook and eat sessions.

The figure represents the number of individuals who have been 'converted' from a contact or attendance at an opportunity to involvement in more sustained engagement. This figure does not contain duplicates of individuals and comprises: n=688 from Bentilee and Townsend; n=519 from Burslem South; and n=471 from Meir North.

A key aspect of the design of this project was the engagement of partners, over the three years of the project; ***102 partners were engaged*** across the three areas. Partners originated from the statutory, private, voluntary and community sectors.

Through the engagement of MHM CDWs in each area, key individuals were easily identifiable as community champions; active, committed, enthusiastic and passionate individuals who were well-known/respected within their community, and often perceived as being 'gate-keepers' to their community. Over the three-year project period ***15 individuals were identified as community champions***. In addition, ***45 volunteers*** were recruited. Of these, ***15 were regularly involved*** in My Health Matters activities.

Follow-up ***telephone interviews*** for a sub-sample (n=181) of engaged My Health Matters participants (n=1,678) were also conducted to assess changes in physical activity and healthy eating behavior over time. ***Results*** demonstrated a statistically significant, positive change from baseline to follow-up in physical activity levels and future intentions to participate in moderate physical activity. A similar statistically significant, positive change was found for daily fruit and vegetable intake from baseline to follow-up.

To develop and deliver interventions there was, in some instances, a requirement for ***building community capacity***. Eight project Community Champions were supported in undertaking training to become community researchers. These individuals undertook a Level 1 course entitled 'Get Talking – Developing Approaches to Creative Consultation' at Staffordshire University. This course was designed to provide participants

with; knowledge and understanding of the context of participatory approaches to involving local people in decision-making; the opportunity to demonstrate the application of different approaches to creative community consultations; and the skills to support and train volunteers in creative consultation methods. Community champions then applied this training to the development of interventions in their respective areas.

A number of community members were also trained in first-aid and food hygiene. This allowed them to take an active role in the development and delivery of interventions (e.g., cook and eat sessions).

d) Qualitative Process Evaluation

Six focus group discussions with 36 residents (n=30 female, aged 32-70 years) and 7 face-to-face or telephone interviews with partner agencies (n=5 female) was undertaken. A focus group discussion was also conducted with 12 community champions (n=9 female, aged 49-69 years).

Community members stated that 'health is not always a priority'. This highlighted the importance of supporting communities to identify and prioritise their own issues. My Health Matters was viewed as a mechanism for bringing people together, linking services and ensuring 'communities communicate'. Focus group participants identified that people often 'don't know what's available on their door step' and frequently, it is 'word of mouth' that is most effective in promoting projects. Concepts relating to social capital were also evident with participants identifying that 'we all have skills, even if we don't know it' and that the My Health Matters project gives people the opportunity to 'give something back' to their community.

Discussion

The need for a community-led collaborative approach to combating inequalities in health has grown out of the recognition that many of the complex determinants of health lie beyond the control of the individual and even of clinical and public health institutions alone. Social factors have a strong influence on health and longevity. Those in deprived areas often: lack access to health services, which reduces their likelihood of early detection; have poor access to fresh affordable food, and areas to play and participate in physical activities (e.g., green spaces of sufficient quality); and often exhibit a number of modifiable risk factors (e.g., smoking, physical inactivity, high alcohol intake) that compound health issues. In addition, those living in poor areas are more likely to suffer from depression, stress and poor mental health [19, 20].

The community development approach to health improvement used in this project emphasised the importance of local relevance and context. Thus the precise health issues and intervention(s) developed could not be defined *a priori*. Working with communities, essentially with a 'blank slate', challenged residents to think about what they could do to improve the health and well being of themselves and their neighbourhood. This is in contrast to individuals reported experiences of being 'told what to do' in relation to their health. Central to the community development approach is "*changing the relationships between ordinary people and people in positions of power, so that everyone can take part in the issues that affect their lives. It starts from the principle that within any community there is a wealth of knowledge and experience which, if used in creative ways, can be channeled into collective action to achieve the communities' desired goals*" [21].

The My Health Matters Project supports individuals to identify their assets and share their skills, knowledge and experiences with the wider community, improving aspects of social capital and health behaviours.

Successes

There are a number of notable successes from this project that include;

• Improved physical activity and healthy eating behaviours.

• Increased opportunities for residents to take part in physical activity by reducing barriers identified by community members.

• Increased access to fresh fruit and vegetables through intervention activities. Any activity undertaken by CDW's incorporated the distribution of fresh fruit and vegetables which, in many cases were donated by local business, e.g. Tesco, co-op.

• Improvement in aspects of social capital e.g., perceptions of anti-social behaviour and problems with teenagers and vandalism.

• The 'My Health Matters' brand and Community Development Workers is well known in the targeted areas.

• Partnership development with community groups, local services and the voluntary sector and support from ward councilors.

• Each area was successful in leveraging funds from a variety of sources e.g. local businesses sponsoring fruit and vegetable distribution (Bentilee and Townsend: £8,577, Burslem South: £44,590, Meir North: £6,750).

• Community champions using their skills in each study area (e.g., delivery of cook and eat sessions).

• A variety of methods have been used to address health issues. Health is not always a priority and therefore it is essential to use creative ways of introducing health-related topics.

• Better knowledge of and utilisation of public spaces: My Health Matters has used a wide variety of the community facilities and assets in each area. Residents are more aware of the assets in their community.

• Identifying and mobilising assets, including, capacity, skills, knowledge, existing connections and potential within a community.

• Supporting vulnerable groups within the City through partnership working in delivering interventions.

• A number of interventions are fully sustainable and delivered by community members themselves (e.g., St. Maria Goretti Garden Project (Bentilee and Townsend), the ROC Café (Cobridge, Burslem South)).

• MHM CDW's have developed a wealth of knowledge, skills and experience of communities within Stoke-on-Trent and in implementing a community development approach to health improvement.

Key Learning

There are a number of key learning points, including;

• The importance of being open and honest with community members, not providing any false promises.

• Deliver 'quick wins' to demonstrate that action can be achieved. This aids the development of rapport and trust.

• Using a bottom-up, community-led approach aids the development of trust in communities as it demonstrates that their views are valued. This is particularly important in times of austerity.

• The importance of providing ongoing support mechanisms to groups and communities throughout the process.

• Sustainability needs to be built into programmes from the outset.

• The importance of supporting empowerment and ownership of programmes within communities.

• Realising the power of individuals within communities to influence peers and the importance of 'gate keepers' in engaging communities.

• It is important to use an asset-based approach, focusing on the positives in communities, including the value of skills, experience and local knowledge of individuals.

• The importance of partnership working. Making health 'everybody's business' and making the most of resources by working together.

• This community development approach to health improvement recognises the part that everyone can play in addressing the social and wider determinants of health.

• The importance of ongoing monitoring and evaluation.

Summary

On the basis of the evaluation the My Health Matters project demonstrated that a community-led approach has the potential to influence health-related behaviour and address some of the wider determinants of health. This approach focuses on supporting communities to take ***ownership and control*** of their own lives by promoting ***community empowerment*** and ***building community capacity***. This project highlighted the important role of residents in identifying and targeting health-related issues linked to facilitating physical activity and healthier eating.

Overall, the My Health Matters project was viewed positively by participants who highlighted the pivotal role that local people can play in shaping local decisions and addressing public health problems. The biggest challenge in engaging communities was overcoming apathy, especially in increasingly cynical, over-consulted areas without evidence of subsequent action. It is important to recognise that change does not happen overnight and partnerships need to be cultivated at all levels to ensure ongoing success.

This approach demonstrates that supporting locally determined health and well-being priorities, and actions to address them, can have a positive impact on a range of individual and community outcomes.

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