Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

Olamide Anike Sadare

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Abstract

Background: Community engagement has become mainstream practice in many sectors, such that many might say that it has become another box to be ticked when planning and delivering projects. There are many potential benefits of community engagement to the residents, local stakeholders and external delivery agencies; however gaps have been identified in the evaluation of impact, barriers and facilitators of community engagement (NICE, 2008). This study prospectively looks at how the process of community engagement under the Well London programme (a five-year health promotion programme which addresses physical activity, diet and mental wellbeing) was delivered in multiple deprived neighbourhoods, and how this process influenced the different stakeholders and the health promotion projects delivered.

Methods: This study used a mixed method approach to examine the process, perceptions, impacts, incentives, barriers and challenges of community engagement. Data were collected through literature review, questionnaire surveys, participant observation, qualitative interviews and evidence from documentary sources.

Results: The study found that the World Café and appreciative enquiry approaches used were useful and effective tools for engaging communities; and the primary motivation for residents' participation was the desire to belong to a community which they could help shape for the better. Key lessons from the process are the need to manage the expectations of local stakeholders and residents by effectively communicating programme goals and limitations; and the need for sufficient time to build relationships and trust for engagement. Residents' level of engagement was influenced by past experiences of consultation processes, local politics and regeneration. There is a need to have good knowledge of the community that is being engaged, and to know the local context and peculiarities which differentiate communities.

Conclusion:

Residents of different ages, gender and cultures engage differently and processes should be sensitive to, and accommodate these differences**.** The impact of the CEP on the design and delivery of projects was inconclusive.

Table of Content

List of Abbreviations

Abbreviation	Full Meaning
ACE-L	Arts Council England, London
AE	Appreciative Enquiry
BLF	Big Lottery Fund
CAW	Community Action Workshop
CEP	Community Engagement Process
CC	Community Cafe
C-YMCA	Central Young Men Christian Association
GW	Ground Work
IHHD	Institute for Health and Human Development
IMD	Indices of Multiple Deprivation
LHC	London Health Commission
LSOA	Lower Super Output Area
LSX	London Sustainability Exchange
PID	Project Implementation Document
PIM	Project Initiation Meeting
SLAM	South London and Maudsley NHS Foundation Trust
UEL	University of East London
WC	World Cafe
WL	Well London Programme

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"DON'T DO ANYTHING FOR US WITHOUT US"

- Anonymous

Chapter 1 – Introduction

1.1. Introduction

Empowering communities through engaging them in decision-making processes about factors which determine their health has been long advocated for by community development workers and health promoters (Labonte, 2008). Community empowerment enables people to take control over health-related factors by taking ownership of the local needs, priorities and solutions (Baum, 2008). However, the degree of empowerment and health advantage the communities achieve are often determined by the extent, type and perceived benefits of the engagement. At present, although community engagement has been well supported at different decision-making levels, little is known about the impacts of types and mechanisms of engagement, and perception by different engaging agencies and the communities themselves.

This study examines the process and the impact of community engagement on the design and delivery of health promotion interventions within Well London (WL), a large health promotion programme which has been delivered in multiple disadvantaged communities in the city of London. The study examines the community engagement process (CEP) from the perspectives of the communities, local stakeholders and project delivery partner organisations.

The WL programme is a health promotion intervention focused on diet, physical activity and mental health, and developed and delivered in 20 communities by seven partner organisations. Community engagement was an integral and fundamental part of the programme and was implemented by the Institute for Health and Human Development (IHHD) in the University of East London (UEL). The CEP entailed involving the local communities through community events such as community cafes, community action workshops and project implementation meetings, in the identification of their health needs and possible ways of addressing those needs. Chapter three of this thesis focuses on the WL programme and gives more details about the community engagement events, the participants and the target populations.

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The researcher affirms a position of scholarly community health activism. The researcher worked alongside the community engagement team of IHHD in the planning and delivery of the community engagement events. This opportunity afforded acquisition of skills around communication, agenda-setting and multi-agency working. Reflexively, the community engagement team acted as catalyst and enabler of the process; trying to maintain a position of neutrality around what was known about the communities and the need to find out more about the communities; between being an external stakeholder organisation and being accepted and trusted as an insider by the communities; and between being seen as a benefactor to the communities and having a benefactor (funder) to whom they must report.

1.2. Rationale and Theoretical Underpinnings

Academic literature suggests that community engagement is a strong basis for successful health promotion interventions (Labonte, 2008; WHO, 2003). Community engagement is viewed as a defining principle of health promotion and a strategy for reducing health inequalities, especially in disadvantaged communities (NICE, 2008; Glanz, Lewis & Rimer, 1997; Wallerstein, 1992; Rappaport, 1984). Although community engagement is widely supported at the conceptual level, very few studies have prospectively observed and documented community engagement events and the empirical evidence on the benefits and impact of community engagement on health is rather weak (Tindana et al., 2007). The National Institute for Health and Clinical Excellence (NICE) in its Public Health Guidance 9 document (Community Engagement to Improve Health) published in February 2008, made recommendations for more research into the methodology, impact, barriers and facilitators, and economic benefits of community engagement (NICE, 2008).

In following these recommendations, this study aims to address the current knowledge gap around the methods and processes of engagement, its barriers and facilitators, and the impact on health promotion actions. Economic evaluation has not been addressed in this specific study and will need to be a focus of future research. This study used a mixed method approach to explore the different perspectives of multiple stakeholders involved in the engagement process; it focused on the incentives for and the challenges of the CEP; it also

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evaluated the impact of the engagement on health promotion interventions and communities themselves.

The study and the CEP have been grounded on the theories of empowerment, which is seen as an ultimate outcome of a community engagement (Christens et al., 2011). The literature on empowerment suggests that disadvantaged communities are powerless because they lack resources or are marginalised from the decision-making process which can give them access to assets, resources and opportunities through which they can change or influence their environments (Parsons, 1995; Mann, 1986). When given an opportunity to express their needs and engage in decision-making, the cycle of social disadvantage and hence powerlessness is broken and there is a shift of power and influence which strengthens communities' abilities to take ownership of their environments and lives (Gaventa, 1980).

The key assumption which underpins this study is that when communities are given an opportunity to formulate and express their needs and collectively identify solutions to local problems, they are more likely to commit to the local actions agreed and to find the resources to support a local change; They are therefore more able to implement the proposed changes and subsequently address their needs (Israel et al., 1994; Zimmerman et al., 1992).

The theories of empowerment and their relationship to this study are further examined in chapter three.

1.3. Aim, Objectives, Research Questions and Methods

1.3.1. Aim

This research aims to evaluate the impact of community engagement in the design, content and delivery of health promotion projects in deprived local communities, and on the communities themselves; and to develop a set of recommendations for future community engagement.

1.3.2. Objectives

The specific objectives are as follows:

- To locate the WL CEP within the theoretical and empirical literature around community engagement and health promotion.

- To examine the process of engagement and range of challenges experienced in the design and delivery of different community engagement events.

- To identify and document the incentives and barriers to community participation, as experienced by the communities and other WL stakeholders.

- To assess whether the process of community engagement itself promoted health and wellbeing or brought other benefits not directly associated with interventions.

- To examine whether and how the WL CEP influenced the design and delivery of health promotion interventions, and impacted on communities and other stakeholders involved.

- To develop a set of recommendations for future community engagement activities in the health promotion field.

1.3.3. Research Questions

The research questions which this study will address are as follows:

1. What is the current framework of best practice for community engagement in design and delivery of health promotion interventions?

2. What are the incentives and barriers to community engagement?

3. How can barriers to community engagement be overcome and the costs to communities met?

4. How does the community engagement process influence the overall fitness for purpose of the intervention design (both positively and negatively)?

5. How does the CEP vary according to the type of issue to be addressed and the type of intervention envisaged?

6. How can community participation be delivered in a way that empowers the local communities and in a way that directly promotes their wellbeing?

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1.3.4. Methods

The research questions above informed the choice of methods used in the study. A mixed method approach was employed due to the multiplicity and wide spectrum of the research questions, and to ensure comprehensiveness of the research process. The methods used were literature review; questionnaire-based surveys; participant observation; qualitative interviews; and evidence from documentary sources; each of these has been described in detail in chapter five of this thesis. Table 1.1 below maps the research questions addressed by each research method.

Table 1.1 – Research questions mapped against research methods used in the study

Research method used	Research question answered
Literature Review	1; 2; 3
Questionnaire Survey	2; 3; 6
Participant Observation	4; 5; 6
Qualitative Interviews	1; 2; 3; 4; 5; 6
Evidence from Documentary Sources	4; 5

1.4. Structure of Thesis

The next two chapters review the literature on health and community engagement. Chapter two looks at the literature on health and wellbeing with particular emphasis on health in the UK; it explores how health disparities and inequalities are produced from the unequal distribution of factors which determine health outcomes such as social status, income and educational attainment; and how these factors interact to produce ill-health. The chapter also looks at how these health inequalities abound in certain groups and communities such as marginalised groups which have complex interacting factors which are detrimental to health. The second part of the chapter examines how health promotion can help to reduce these health disparities and the policy frameworks that have aimed to improve health in the UK through promotion of healthy eating, physical activity and mental wellbeing in communities. Chapter three follows on the review of health promotion and

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examines the links between health promotion and community engagement through the conceptual framework of empowerment; it examines how health interventions may work better and more effectively in the communities that are engaged. The chapter also focuses on the processes, approaches and levels of engagement; factors which affect level of engagement; the incentives and barriers to community engagement; some examples of community engagement for health promotion; and policy frameworks around community engagement in the UK. Figure 1.1 below gives a representation of the logical flow of ideas in the literature review chapters.

Figure 1.1 – Logical flow of literature review chapters
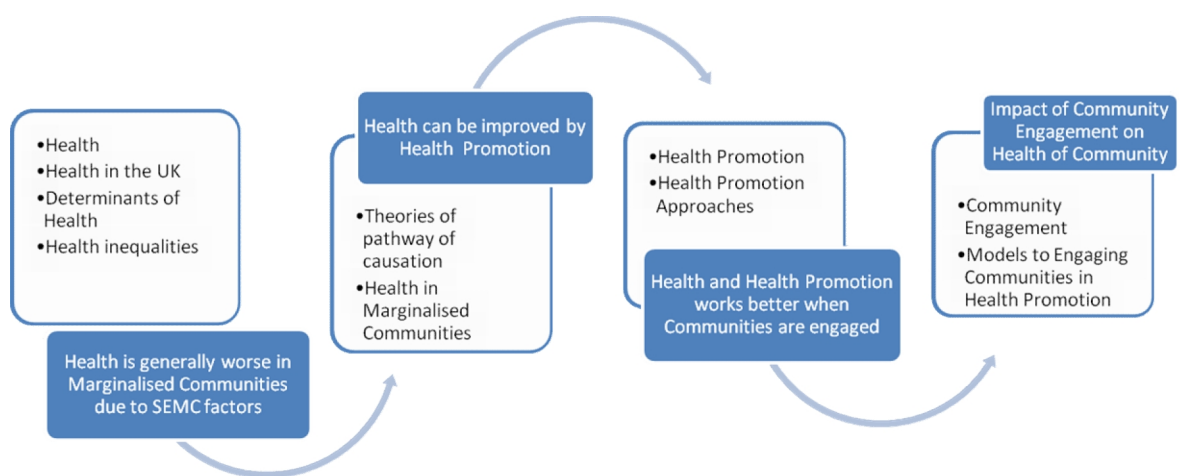
Chapter four describes the WL programme and the CEP events. It catalogues the WL community selection process, CEP, alliance partner organisations and projects; and describes the background and the context of the data presented in further chapters. Chapter five details the research design and methods used to answer the research questions. The next five chapters (six, seven, eight, nine and ten) are the results chapters. Chapter six provides the results from the participant observation of the target communities and their community engagement events. Chapters seven, eight and nine describe the WL CEP and its impact from the community residents', local stakeholders' and WL alliance partners' perspectives respectively. Chapter ten presents the analysis of the WL documents related to the CEP. Chapter 11 discusses the findings of the study, and its limitations and strengths, original contributions, conclusions, and recommendations.

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Chapter 2 – Literature Review:

Health, Health Inequalities and Health Promotion

2.1. Introduction

This chapter reviews published literature on health, health inequalities and health promotion with the aim of pooling together the existing knowledge on these subjects, providing a background and academic context for this study.

The literature review explores the understanding of health, what determines health, how health and ill-health are distributed within and between different communities, and how health may be improved through health promotion interventions. Thus, this chapter looks at health and its determinants, and how these determinants are distributed in society, leading to differences in health status and health outcomes of different population groups. In particular, health in the United Kingdom (UK) will be explored by describing the burden of disease and health inequalities that exist in the country; and the policy frameworks that have been developed over the years to tackle health inequality challenges.

Determinants of health will be explored in some detail to illustrate how they may interact or co-exist to produce health inequalities and inequities. These inequities are demonstrated in societies and may cause marginalisation of certain individuals, groups and communities. This review will therefore also look at the links between health and marginalisation; how health in marginalised or disadvantaged communities compare with the general population, and how health can be improved through health promotion interventions in these communities. Health promotion will be examined through its development over time and the policies that drive the current public health practice.

The literature search was done electronically, using keywords: health; wellbeing; health in the UK; health inequalities; determinants of health; health promotion; theories of health promotion; empowerment; marginalization. Search was limited by year of publication 1986 to 2009; however through the course of the literature review, certain relevant literature dating before 1986 were included. In addition, the websites of the Department of Health, National Institute for Health Clinical Excellence and the World Health Organization were

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searched for relevant publications using the same keywords. In total, over 250 papers, books, book chapters, reports, reviews and other publications were reviewed.

2.2. Health

Health is a complex concept with diverse definitions and dimensions including physical, mental, social (WHO, 1948), emotional, societal and spiritual (WHO, 1984; 1948). Health fundamentally requires the presence of peace, shelter, education, social security, adequate sanitation, access to adequate health information, social relations, food, income, empowerment, stable ecosystem, sustainable resource use, social justice, respect for human rights and equity (UNICEF, 1948; Marmot, 2006).

A key concept in the understanding of health is wellbeing. Wellbeing goes beyond the general assumptions of happiness and satisfaction; it is the objective and subjective measures of quality of life which is determined by physical health, employment, income, housing, social networks, community participation and education. It shapes people's lives and opportunities (Fahey et al., 2003). It is a multidimensional concept of the interplay of factors which affect people's lives and the ability of an individual to make meaningful contributions to his community (Costanza et al., 2008; DEFRA, 2007); to flourish and thrive through positive and sustainable opportunities provided by good working and living conditions (WHO, 1948). For the purpose of this thesis, the terms 'health' and 'wellbeing' will be used synonymously to denote dynamic and positive processes which encompass various dimensions described above.

The World Health Organization (WHO) for over 60 years has defined health as an absolute physical, mental and social wellness in the absence of biological disease – *'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (Official Records of the World Health Organization, no. 2, p.100, 1948). This *state* of health implied by the WHO definition has been challenged by many writers (Aggleton, 1991; Dubos, 1987). Some critics argue that this definition excludes the emotional and spiritual dimensions; while others are against the reference to health as a

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stagnant state or an end-product; they view it as a dynamic relationship of interacting factors, a capacity to cope and contribute to society, a potential to aspire and realise aspirations, and a process (Laverack, 2004). They argue that the WHO definition is idealistic and impossible to achieve because complete freedom from disease is virtually impossible within the context of living (Aggleton, 1991; Dubos, 1987). Therefore several researchers in the field of health and sociology have attempted to explain health, rather than define it. WHO (1984) addressed some of these critical views by later referring to health as a dynamic process, rather than a state of being; and identifying the need for the ability to change and cope with the environment, and to use health as a resource for daily living (WHO, 1984). Health is a basic human right of every individual, and it is required for the social and economic development of both the individual and the community in which he/she lives. This right to health includes the right to healthcare, safe drinking water, adequate sanitation, access to health-related information and a standard of living sufficient to maintain health and wellbeing (United Nations, 1948). Improvements in these basic rights along with better nutrition and reduction in family size, coupled with immunization, medical services and therapies have been responsible for the improvements in health and the decline in mortality due to infectious diseases over the last century (McKeown, 1979).

Nancy Milio (1983) viewed health as an individual's ability to stay in tune with his/her biology (and biological clock) internally, and his/her social environment externally (Milio, 1983). This takes into account unavoidable factors that affect health such as age and gender differences. Perceptions of health also vary with these differences; therefore, older people are more likely to define health as wholeness, inner strength and ability to cope (Williams, 1983) while young people are more likely to see health in terms of fitness, energy or strength (Blaxter, 1990). Similarly, men describe health positively as being fit, while women have a negative notion of health as not being ill, or being able to carry out daily chores (Blaxter, 1990). Health is a personal thing and is likely to be defined subjectively by the individual, taking into account their capability to thrive (Mansfield, 1977). However, health is not independent of one's context; a measure of health is therefore, the ability of an individual to function in a way that is acceptable to him/her and the community of which he/she is a part

(Dubois, 1979). Health is created and lived by people within the settings of their daily lives in schools, places of work and recreation, and at home (WHO, 1986).

The collective health of a group or community is public health, and has traditionally been defined to acknowledge the 'organised efforts of society' or 'collective or social action' in the prevention of disease and promotion of health to prolong life (Acheson, 1988). Derek Wanless (2004) and a number of authors in the past two decades argued that a further emphasis should be placed on the organised efforts and informed choices of society, communities and individuals (DH, 2004; Acheson, 1988; Last, 1987). This stresses the importance of providing people with information and engaging them in the decisions that affect their health and lives; and that roles and responsibilities for public health lie with all sectors of government, private organisations, society at the national and local level, as well as with individuals (Wanless, 2004). Such understanding of health acknowledges that health and illness are dependent on a multitude of complex and interacting systems which are usually out of the control of the individual, rather than by a single causative factor (Ogden, 2008); and that some biological and social factors, and psychological beliefs and behaviour are essential contributors to one's health (Engel, 1977, 1980). These contributors are called determinants of health (Wilkinson & Marmot, 2003).

2.3. Determinants of Health

Determinants of health are the factors which influence health and have an impact on health-related outcomes; they are economically, politically and socially sensitive, and often go beyond the control of individuals (Marmot & Wilkinson, 2006; Evans, et al., 1994; McKeown, 1979). These factors are multiple and include biology and genetics; personal health practices and coping skills; gender; culture; early child development; physical environment; social environment; socio-economic circumstances such as income, social support, education; employment and working conditions; and health and social services (Marmot & Wilkinson, 2006; Raphael, 2004; Wilkinson & Marmot, 2003).

Dahlgren and Whitehead (1991) broadly classified the determinants of health into five layers: biological and hereditary; individual lifestyle; social and

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community networks; living and working conditions; and general socioeconomic, cultural and environmental conditions (Dahlgren and Whitehead, 1991). The relationship between these layers is shown figure 2.1 below.

Figure 2.1 – Determinants of health. *Source: Dahlgren and Whitehead (1991)*
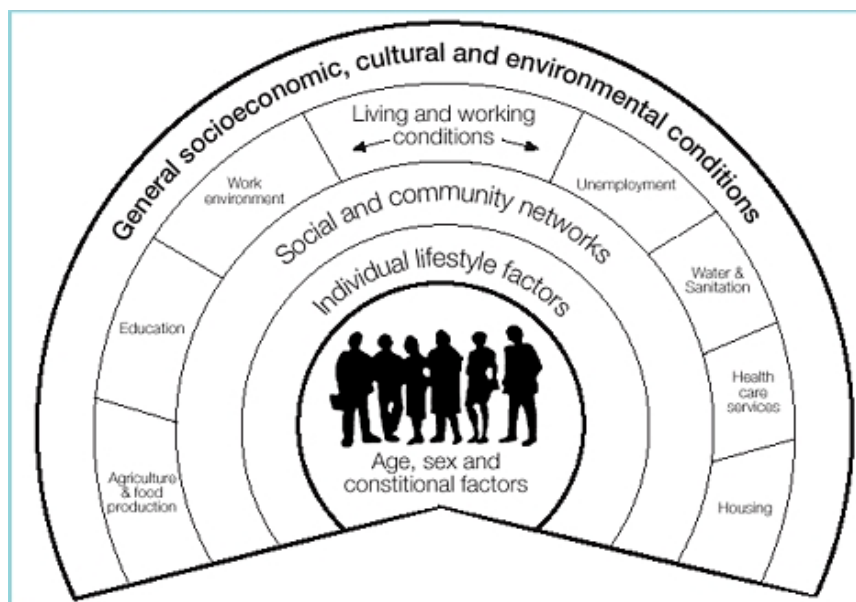
Biological and hereditary factors such as age, sex and constitutional factors cannot be changed. Health differences which result from these are consequences of the biological variations between men and women and the diseases they suffer at different ages; and the genetic inheritance and ethnic variations which play a role in determining risk of certain diseases (Jackson, 2004; WHO, 2009). Other groups of factors can be changed or modified to improve the health of individuals and communities; they are however beyond the direct control of the individual and require the collective effort of the government, organisations and communities (WHO, 2009; Marmot & Wilkinson, 2006; Evans, et al., 1994; McKeown, 1979). These factors are termed the socio-economic, cultural and lifestyle determinants of health (Wilkinson & Marmot, 2003).

There are also political determinants of health which influence wider contextual factors by deciding priorities of who gets what, when and how (Engels, 1845/1987; Laswell, 1936). Political power is exercised over many determinants such as housing, income, security and employment (Blas & Kurup, 2010; Bambra et al, 2008). The government in power will also influence health and it

determinants through the exercise of its sociological and political ideologies. Politics influence health through legislation and policy-making, examples of which are the ban on smoking in public places, speed limit regulations, seat belt regulations, employment and disability rights acts, and regulation of advertising (Bambra et al, 2008).

Socio-economic circumstances are important determinants as they are responsible for influencing factors such as housing, education and social support. These factors are believed to be of greater importance than the commonly considered issues of personal lifestyles, physical area assets, or access too and use of healthcare services (Marmot & Wilkinson, 2006; Evans et al., 1994; McKeown, 1979). Alcohol misuse, cardiovascular diseases, children's nutrition, food safety, mental disorders, tropical diseases, oral diseases, unplanned pregnancy, adverse outcomes of pregnancy, tuberculosis, violence and injury are among the key health problems of today, and all are shown to be related to socio-economic status (Blas & Kurup, 2010).

Thus, we now know that lifestyle behaviours are a way of living based on interplay between personal attributes, social interactions, socioeconomic and environmental living conditions (Nutbeam, 1998). Some lifestyle behaviours are reinforced by socioeconomic, cultural and environmental factors; and socioeconomic disadvantage is often a marker for harmful lifestyle behaviours such as alcohol dependence, drug abuse and smoking (Nutbeam, 1998). People may enter into these harmful behaviours to provide a temporary release from the pain and hardships of their socioeconomic conditions and its associated stress (Marmot and Wilkinson, 1999) especially people from marginalised groups, people in prison and some ethnic minority groups (Ewles, 2005).

The physical environments in which people live, work and play are products of their socio-economic circumstances; and these are associated with health outcomes (Corburn, 2004; Barton, 2000; WHO, 1998). For example, urban design and environmental planning have been intrinsically linked to travel behaviour and physical activity (Whitacre & Burns, 2010; Corburn, 2004; Hoehner et al., 2003). Poor housing conditions have been linked to communicable diseases such as tuberculosis and a range of respiratory problems (Marmot, 2011). Deprived areas are known to have smaller numbers and sizes of green spaces,

sports areas, and other environmental amenities; and are linked to heavier pollution, lower levels of physical activity and poorer mental health (Powell et al, 2004).

The roles of individual behaviours and environmental factors are important and there are continuous debates on which of these groups of factors should be priorities in health policies and actions. Donaldson's (1999) for example, outlines a number of tips for staying healthy which do not take into consideration social determinants of health; they largely suggest that the individual is in control of his/her lifestyle behaviours such as smoking or unhealthy diet, and can manage the day-to-day stresses in life (Raphael, 2004; Donaldson, 1999). The authors who do not agree with such approach argue that many behavioural factors lie beyond an individual's control and are the results of policies and conditions within which people live. Thus, in response to Donaldson (1999), Gordon (1999) gives his own tips for better health such as not being poor or having poor parents; owning a car; staying employed and not working a stressful, low paid manual job; not living in poor quality housing or one close to areas of pollution; going on frequent sunny holidays; and having high literacy and numeracy levels which allow negotiating government bureaucracy and claiming benefits to which the individual is entitled to. He argues that these are the factors that have primary responsibility for individual health (Gordon, 1999).

It was argued that socio-economic determinants have an iceberg effect because they are the underlying powerful force which lies beneath the health status seen on the surface; they are bigger and have a more profound effect than what we visualise as health (figure 2.2), therefore policies to address them need to run deeper (Baum, 2009).

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions
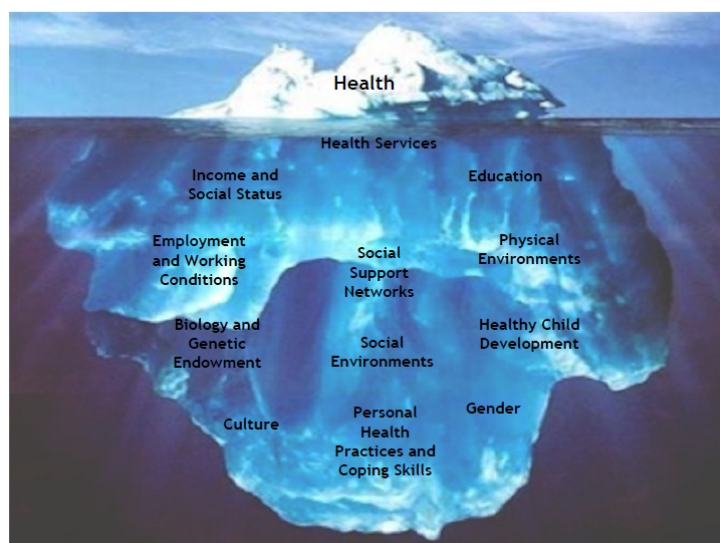
2.3.1. Poverty and Health

Poverty is a difficult term to define, but it usually refers to material, economic or social deprivation which causes unacceptable hardship (Piachaud, 1981). Poverty, in its most basic and general sense is the lack of food, shelter, clothing, warmth, medical care and safety; although what is necessity to one person is not uniformly a necessity to others (Bradshaw, 2007).

Poverty is generally presented in terms of 'absolute' and 'relative' poverty; absolute poverty is based on the minimum standard required to live and sustain life on the basis of minimum need which is referred to as 'the poverty line' (Rowntree, 1901). The poverty line was introduced in the US based on three times the estimate of what a family would require for an adequate but not lavish diet (Orshansky, 1963). It now generally refers to the minimum amount of income a family would require to have an adequate standard of living in a given country (Ravallion, 1992). Relative poverty, on the other hand, is based on a comparison of a group to another in society and this implies that relativity standards by which poverty is measured can be different from one community to the next (World Bank, 2008).

There are different theories of the origins of poverty - individual deficiencies; economic, political or social distortions; discrimination; geographical disparities;

and cumulative and cyclical interdependencies (Bradshaw, 2007). Some theorists place emphasis on individual pathological explanations which assume that people are poor because of bad lifestyle choices and generational habits and behaviours that run in families; others focus on structural explanations of poverty resulting from marginalisation, failure of government or public services, and inequality in society (Bradshaw, 2003; Blank, 1997). Some others point out that low-income people are often concentrated in more disadvantaged areas which socially and geographically reinforce their isolation from resources (Furstenberg et al., 1999; Wilson, 1987). Living in such isolated resource-deficient neighbourhoods for a long period can produce a culture of poverty, and predispose to the inter-generational transmission of poverty (Wilson, 1987).

The view of poverty we ultimately embrace has a direct bearing on the public policies we pursue (Schiller, 1989). The debates on whether place-based or person-based approaches are more effective in reducing poverty is on-going, however, an increasing number of authors agree that neither approach alone is sufficient (Davis & Bosley, 2007); and therefore, poverty-related interventions should focus on both individual and structural determinants.

In the UK, poverty is described in relative terms, as perceived by people and what they recognise as the minimum acceptable standard of living in present-day Britain (Pantazis et al, 2006; Marmot, 2006, 2006c; Shaw et al, 1999). Studies of the geography of poverty in the UK found the highest rates of poverty in central and remote rural counties, and the lowest rates in the fringe counties of large metropolitan areas (Fisher, 2005). Such geographical variations relate largely to lower wages (Economic Research Service, 2000) and other forms of underemployment (Slack & Jenson, 2002; Jensen et al., 1999; Economic Research Service, 1995; Lichter, Johnston & McLaughlin, 1994; Lichter & Costanzo, 1987). There is also evidence of high poverty rates in urban ghettos and council estates (McLeod, 1987) determined by unequal opportunities for education, employment and leadership (Richardson & London, 2007). Socio-economic groups at greatest risk of poverty UK include those in receipt of income support (71%), incapacity benefits (46%) and tax credits (22%); lone parents (48%) and mothers under 25 years (41%); workless households (75%); households with four or more children (50%); Pakistani/Bangladeshi ethnicity (57%) and Black ethnicity (43%) (Child Poverty Action Group, 2006). Older

people with low-income or pensions are more likely to live in poverty (Patsios, 2006).

Poverty in developing countries affects health through poor living conditions, unsanitary environments, poor healthcare, infections and malnutrition (World Bank, 2006; United Nations-OHCHR, 2006), and socio-economic imbalances lead to disparities in health (Narayan et al., 2000).

Poverty is the biggest enemy of health and goes beyond insufficient or lack of income (Marmot et al., 2010; Dodd & Munck, 2002). Studies show that poverty and disease go hand in hand (Pond, 1961), and poverty affects the course of illness and disease, and access to and use of available healthcare (Weitz, 2009).

Poverty has been shown to be more than economic deprivation; thus, when 60,000 people in 47 countries were interviewed by the World Bank about what relief of poverty meant to them, they said poverty was more than just the scarcity or lack of money and material resources; they wanted opportunities, empowerment, dignity and security (Narayan et al., 2000).

Multiple studies showed that poor health is related not only to economic disadvantage (WHO, 2008; Ewles, 2005), but also to social class (Marmot & Brunner, 2005; Labonte, 1993; Kasl & Cooper, 1987; Antonoovsky, 1967), education (Suhrcke & de Paz Nieves, 2011; Erikson, 2001), employment (Bartley et al, 2004; Marmot and Wilkinson, 1999; Platt, 1984), social networks (WHO, 2009; Almedom & Glandon, 2008; Fowler & Christakis, 2008; Marmot and Wilkinson, 1999; Putnam, 1995) and culture (WHO, 2009; Burch, 2008). The shift from poverty to social deprivation represents an acknowledgement that inequality arises not from mere income differentials and material disadvantage, but from a combination of linked social factors. These factors include those directly related to poverty (unemployment, low incomes and poor housing) and those which are as a result of the socio-political environment (poor skills, high crime, poor health, family breakdown and isolation) (Social Exclusion Unit, 1997). These factors are usually related and produce a multiplier effect on the health-related risks and associated illnesses, disability and mortality (Marmot & Wilkinson, 1999).

2.3.2. Social Disadvantage and Health

Health follows a social gradient where socio-economic position determines health (Sanders et al, 2008; WHO, 2008) and the greater the gap in socio-economic status between the rich and the poor is, the greater the health differences are (WHO, 2009). A greater income and a higher social status are inextricably linked, and they both determine health through greater opportunities, influence, power, and control (Labonte, 1993) and through increased social mobility (Fabian Society, 2006). A lower social status leads to continuous experiences of stress and subsequent health risks such as high blood pressure, cardio-vascular morbidity, and depression (Marmot & Brunner, 2005; Kasl & Cooper, 1987). As a result, people in lower social positions have consistently shown poorer health and mortality indicators than those in the upper social class (Marmot, 2006; Kunz-Ebrecht et al, 2004; Brunner et al, 2002; Marmot and Wilkinson, 1999; Brunner, 1997; Antonoovsky, 1967)

Job security also influences health with unemployment and poor working conditions causing illnesses, depression and premature death (Bartley et al, 2004; Marmot and Wilkinson, 1999). Epidemiological studies implemented in a variety of countries showed strong and positive associations between unemployment and adverse health outcomes (Jin et al, 1995) including heavy alcohol consumption (Tekin, 2004; McKee, 1999; Chenet et al, 1998); a higher rate of suicide and mental health problems (Bhui et al, 2005; Bartley et al, 2004; Platt, 1984); and high levels of stress (Karasek & Theorell, 1990); while secure employment and good working conditions are associated with better health and increased likelihood of recovery from limiting illness (Bartley, et al, 2004; Marmot and Wilkinson, 1999).

Education is linked to better health through greater opportunities for employment, job security, greater income and increased control over life circumstances (Marmot & Wilkinson, 1999). Furthermore, higher levels of education encourage better health by increasing people's ability to seek health information, and understand and use health knowledge (Marmot & Wilkinson, 1999). Lower educational attainment has been associated with the likelihood of smoking (Suhrcke & de Paz Nieves, 2011; CDC, 2009; Harwood, 2007); unhealthy diet (Suhrcke & de Paz Nieves, 2011); poor oral health (Sanders et al., 2008); and increased mortality, particularly among men (Erikson, 2001).

A number of studies have shown the life-time impact of social disadvantage, where deprivation, family background and childhood health have been important predictors of adult health and mental wellbeing (Mensah & Hobcraft, 2008) Childhood poverty has been consistently associated with poorer health and life opportunities in later life (Fabian Society, 2006; Marmot & Wilkinson, 2003) through detrimental effects on IQ, school achievement, and socio-emotional functioning (Mensah & Hobcraft, 2008; Wilkinson & Marmot, 2003; McLoyd, 1998). Low birth weight is also associated with lower social status of the family, and is a contributory factor to developmental problems (Bartley et al, 1994).

Culture is an important determinant of health as it shapes how we interpret health and illness (WHO, 2009; Burch, 2008; Morgan, 1996). There are cultural variations responsible for people from different cultures reacting to illness in different ways (Zborowski, 1952). It is important to understand how culture affects health especially in multicultural societies because it determines how and from whom we seek help, and whether certain illnesses will cause stigmatisation, marginalisation and unemployment (Baskind & Birbeck, 2005). The differences in the understanding of health-related issues and solutions often lie in the cultural differences in the understanding of health; and the view of health taken determines what is done to get, maintain, sustain and promote health (Burch, 2008); and therefore may vary from community to community (Marshall et al, 2007; DH, 2004; Sport England, 2001). Culture is a system of shared meanings, experiences and practices which is reflected in the customs and areas of social life including religion, ethnicity, diet and dress (Burch, 2008).

Social support and networks of families, friends and communities are linked to better health and wellbeing (WHO, 2009; Almedom & Glandon, 2008; Fowler & Christakis, 2008; Marmot and Wilkinson, 1999; Putnam, 1995). Strong social networks have been associated with reduced deaths from cardiovascular disease and suicide (Rosengren et al, 2004; Putnam, 2000; Kawachi et al, 1996); while being lonely has been associated with health risks, for example high consumption of alcohol (McKee, 1999). The relationship between health and social networks is also related to the concept of social capital which explains how cooperation in the community leads to trust and stronger social cohesion (Shields, 2008; Putnam, 2000). People who have stronger connections to others

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have repeatedly reported better physical and mental health, and are likely to live longer than their lonely counterparts (Putnam, 2000; Kawachi et al., 1996; House et al., 1988). Literature shows that people's wellbeing and other health-related factors depend on the wellbeing of those they are connected to; and that indeed, wellbeing and happiness can be spread from one person to another with the formation of social ties (Fowler & Christakis, 2008).

2.3.3. Marginalisation and Health

The relationship between marginalisation and health roots from the link between powerlessness and increased risk of disease due to lack of control over the determinants of one's health (Baskin, 2003; Young, 2000; Syme, 1988; Haan et al, 1987). The effects of social marginalisation have been shown in multiple studies of migrant groups (Lynam & Cowley, 2007; Ferguson et al., 2005) and indigenous populations (New Zealand Statistics, 2009; Health Canada, 2005).

Marginalisation can occur at three different levels: individual, community and global; but there is a considerable overlap of the levels in most circumstances. It is the exclusion of individuals or groups from mainstream society; and is usually associated with factors such as immigration, ethnic minorities, substance abuse problems and unconventional lifestyles (Ferguson et al., 2005). There is a strong link between marginalisation and social exclusion, and they usually co-exist because factors that make an individual or community marginalised or socially-excluded are usually the same factors which play a role as determinants of their health (Cook & Gilbert, 2006).

Social exclusion involves the segregation or discrimination of individuals or groups from the normal practices, interactions and rights of the society in which they live in (Commission of the European Communities, 1993). It goes beyond income poverty and lack of material resources (Cook & Gilbert, 2006). It is the resultant effect of multidimensional social and economic disadvantage, and it usually takes its toll from childhood through to adulthood and may be transmitted from one generation to another (Cabinet Office Social Exclusion Task Force, 2008; Cook & Gilbert, 2006). Marginalisation can affect health by producing a downward spiral of more deprivation and poorer health because the economic and psychological isolation involved makes it difficult or

impossible for the excluded individuals or groups to act on factors which affect their lives (DH, 1999).

Marginalisation is essentially the process whereby individuals or groups in lower social standing in society are relegated to the periphery of mainstream society by the dominant group who possess political and economic power (Yee, 2005; Mullaly, 2007; Hall, 1999; Hall et al, 1994). Marginalisation is possibly the most powerful form of oppression because it has the potential to exclude entire groups or populations and is capable of producing material deprivation and poorer health through poor access to services (Young, 1990) and exclusion from decision-making processes (Cook & Gilbert, 2006). Furthermore, marginalised groups do not have the resources to oppose the socio-political forces that produce and perpetuate their marginalisation; therefore extreme forms of marginalisation have the potential of totally annihilating the marginalised (Mullaly, 2007).

Marginalisation is emphasised by social justice which is the moral judgement about the fairness of distribution of rewards and benefits. The relationship between marginalisation and health are reciprocal; as marginalisation and social exclusion can lead to poorer health outcomes (Cook & Gilbert, 2006; Germov, 2002; DH, 1999) and poor health can cause, perpetuate and exacerbate poverty and marginalisation (Braveman & Gruskin, 2003).

Cook & Gilbert (2006) provide a meta-synthesis of marginalisation and health research in which they identify the characteristics of marginalised individuals or groups. Those most likely to be marginalised are young and old people; culturally or racially different people; those living in remote geographical areas; those with low education, employment, health or economic status; those with poor access to healthcare or social services; those with drug and/or alcohol addictions; socially isolated individuals; and those in unstable or abusive relationships (Cook & Gilbert, 2006).

Young people may experience marginalisation because of their educational level or employment status; as a consequence of some disharmonious family relationships; or if they are excluded from decision-making processes in their community (Munk, 2002; Horn, 2001). The growing mistrust between adults and young people which has become apparent, particularly in the UK, may be as a

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result of not setting clear boundaries for young people which has led to increased crime and anti-social behaviours and therefore they are trusted even less (Bailey, 2008; Hulme, 2006).

Another marginalised group is that of poor women; women make up nearly 70% of the world's population of poorest people, which is conservatively estimated at 400 million (Hickey & Branking, 2005). The effects and consequences of poverty are greater in women, and the most obvious health issue for women is maternal mortality (Dodd & Munck, 2002).

Although minority groups are the ones that are usually marginalised, this is not always the case as marginalised groups may actually comprise a numerical majority as in the case of Blacks in South Africa (Cook & Gilbert, 2006). Therefore it is important to distinguish marginalised groups from minority groups. A minority group may be small in number but have access to and wield immense political and economic power, and may actually marginalise the majority group (Cook & Gilbert, 2006). In Britain, immigrants mostly make up the minority ethnic groups and they experience disadvantages in both their inability to find work and the pay they get when they do (Dickens & McKnight, 2008). New migrants typically earn less than their British-born counterparts (30% less for men and 15% less for women); this pay gap reduces as their stay in Britain lengthens but it could take up to 20 years for migrant men to close the gap and six years for migrant women (Dickens & McKnight, 2008). Immigrants may be also marginalised through being culturally and/or racially different in their new countries of residence (Cook& Gilbert, 2006; Ferguson et al., 2005).

Health in marginalised communities may be improved by engaging them in decision-making processes which enable them to take control over factors which excluded them in the first place (Laverack, 2008).

2.4. Health Inequalities

As shown above, socio-economic determinants of health often co-exist and interact to produce a complex range of disadvantage both in living conditions and in health outcomes; they also lead to what is commonly known as health inequalities (Evans, 2004)

Health inequalities are the measurable differences or disparities in both the experiences of health and health outcomes between population groups produced by the clustering of circumstances of disadvantage which can be defined geographically, ethnically, socially and economically (Kawachi et al, 2002; Leon et al, 2001). As indicated above, health is determined by multiple factors which are distributed unequally, leading to inequalities (Wilkinson, 2003) which may reduce life expectancy for those on the wrong side of this unbalanced equation (Marmot, 2006). Inequalities result from and are propagated by inequity, which is the lack of fairness or justice (Blas & Kurup, 2010). Sir Michael Marmot (2006) argues that although social hierarchies are inevitable, the resultant health inequalities created by them are not (Marmot, 2006); health should be attainable to every individual regardless of his/her race, religion, political belief, economic or social circumstances (WHO, 1946).

Health is unevenly distributed both between and within population groups (Marmot, 2006; Rifkin et al, 2000); A wide range of empirical studies showed health-damaging effects of social deprivation and resultant health inequalities by gender, race, ethnicity and geographic location (Daykin & Wills, 2008; Braveman & Gruskin, 2003; Evans et al, 2003).

Globally, people around the world are generally wealthier, healthier and living longer today than three decades ago (Marmot, 2006). However, these substantive improvements have been unequally distributed; many countries and groups have been left behind and are increasingly lagging in terms of health and there is considerable body of evidence to show these substantial and rising health inequalities (Marmot, 2006; WHO, 2008). Life expectancy at birth around the world differs considerably from 32.5 years in Swaziland to 82 years in Japan (UNDP, 2005). Furthermore, the Preston Curve which shows the relationship between a country's life expectancy and its per capita income clearly suggests that the richer the country is, the higher its life expectancy (Preston, 1975); this relationship goes up to a point beyond which the relationship between equal distribution of wealth and health are becoming more important (Preston, 1975). In most developed countries today, there is strong evidence to suggest that life expectancy for people at the lower end of the social ladder is shorter, and the prevalence of certain conditions can be twice as high compared to those at the socio-economic top (Marmot & Wilkinson, 1999). A recent report on health inequalities in the city of London

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suggests that the differences in the life expectancies of men and women living in the most and least deprived communities is 7.2 and 4.6 years respectively (Baker et al, 2011).

As health is determined by socioeconomic circumstances which are reflected by social class, employment, education, and social relationships and networks; these are the factors that have major contributions to the disparities in health and therefore should be a primary focus of interventions aiming to reduce health inequality (Suhrcke & de Paz Nieves, 2011; Burch, 2008; Mensah & Hobcraft, 2008; Birckmayer et al, 2004; Rosengren et al, 2004; Hillsdon et al, 2003; Marmot and Wilkinson, 1999; Kawachi et al, 1996; Labonte, 1993; Syme, 1988; Haan et al, 1987).

2.5. Health and Health Inequalities in the United Kingdom

The UK's population of 61 million is expected to rise to 65 million by 2016 due to immigration and an increase in the proportion of people living longer (ONS, 2007; World Health Statistics, 2008). The life expectancy at birth is 77.33 and 81.68 years respectively for males and females, but these vary considerably within populations in the country (ONS, 2007) especially in urban centres such as London where differences in life expectancy can be as much as seven years (Baker et al., 2011).

2.5.1. Disease Burden in the UK

Like many developed countries where lifestyle diseases and non-communicable diseases have overtaken communicable diseases as the leading causes of morbidity and mortality, the top ten causes of death include ischaemic heart disease, lower respiratory tract infection, cerebrovascular disease, respiratory tract cancers, chronic obstructive pulmonary tract disease, colon and rectal cancers, breast cancer, Alzheimer and other dementias, prostate cancer, lymphomas and multiple myeloma (WHO, 2006; DH, 2004). The public health priorities in the UK are therefore cancers; coronary heart diseases and stroke; diabetes; smoking; obesity; sedentary lifestyles and lack of physical activities; traumatic injuries; teenage pregnancy; sexually transmitted infections; alcohol and drug misuse; mental health; and health inequalities (Ewles, 2005).

The diseases responsible for a high proportion of Disability-Adjusted Life Year (DALYs) in the UK are interrelated, and two or more of them can usually be found clustered in the same individuals or communities (Ewles, 2005). Thus, while national prevalence of daily tobacco use is 28% for females and 29% for males (WHO, 2006), smoking is more prevalent in people from lower socio-economic groups, marginalised groups, people in prison, and in some ethnic groups (Nutbeam, 1998). Similarly, teenage pregnancy is far more common in disadvantaged groups, including women with lower levels of education, those who have spent some time in the social care system or prison, and those living in poverty and unemployment (Ewles, 2005).

Sedentary lifestyles with little or no physical activity and poor diet has led to high levels of obesity and has become one of the biggest threats to the health of people in the UK where about a quarter of the adult population is classified as obese, and over half are overweight (Eurostat, 2009; DH, 2008; DH, 2004). These levels of obesity and overweight has led to higher incidence and prevalence of diseases such as type 2 diabetes, heart diseases, breast and prostate cancers, gall bladder disease, osteoarthritis, complications in pregnancy and others (DH, 2004; Marmot and Wilkinson, 1999). Poor socio-economic factors are also risk factors for obesity and overweight with a slightly higher prevalence of obesity in manual than non-manual workers (Mulvihill & Quigley, 2003).

2.5.2. Health Inequalities in the United Kingdom

Social disparities in health in the UK have been known since the mid-1800s when Friedrich Engels (1845/1987) reported on the health of working class people and the differences in health status, morbidity and mortality. High rates of infectious diseases, stress, injuries and alcohol misuse were linked to poverty, unsanitary conditions, poor housing, lack of food safety, poor mental health and internal control, and adverse health behaviours (Raphael, 2004; Engels, 1845/1987). About the same time Rudolf Virchow (1848) produced a report on the typhus epidemic in Western Europe and linked poor health outcomes to the lack of democracy and human rights, unjust taxation, and politics (Raphael, 2004; Virchow, 1848/1985).

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William Farr first documented health inequalities in 1837; this was followed by the works of Joseph Rowntree in 1901; Booth in 1902-03; Boyd Orr in 1936; Titmuss in 1943; and Tudor Hart in 1971 (Davey et al, 2001).

The National Health Service (NHS) which was introduced in the UK in 1948 to address the unequal access to healthcare by providing free healthcare at the point of use, has not achieved substantial reduction in health inequalities (Acheson, 1998; Whitehead, 1992; Townsend & Davidson, 1980). Thus, 30 years after the foundation of the NHS, Sir Douglas Black in 1980 reported that a class gradient still persisted for most causes of death and for life expectancy at birth (DHSS, 1980).

Further reports on health inequalities in the UK included the *'Health Divide'* (Whitehead, 1987) commissioned by the Conservative government; and the *'Acheson Report'* (DH, 1998) commissioned by the New Labour government in 1997. They all showed that whereas in general throughout the 20th century, health outcomes in the UK had improved, the gaps between the different social classes still existed and were increasing (Evans, 2005). The New Labour government elected in 1997 came in with a strong commitment and determination to improve public health and reduce health inequalities by tackling poverty and social exclusion in a joined-up and upstream manner (Evans, 2004); and in 2003, the Department of Health published a strategy document through which the Government would tackle inequalities in the UK. This document, *'Tackling Health Inequalities'* (2003) followed the evidence presented in the Acheson Report (1998) and set up key targets to reduce inequalities contained in '*Saving Lives: Our Healthier Nation'* and '*Reducing Health Inequalities: An Action Report',* both published in 1999.

There are various ways to consider health inequalities and in the UK, variations in health outcomes are presented by social class or geographic locations (London Health Observatory, 2006; Hanlon et al., 2006; Marmot & Shipley, 1996; Marmot et al., 1978). Consideration of health inequalities by race is less common (Marmot, 2006) and there have been arguments as to whether racial differences symbolise greater differences than just socio-economic ones; whether racial differences lies behind the UK social gradient; and whether differences are determined by the individual, the socio-economic status or environment (Marmot, 2006; Williams, 1999). Whether health data is analysed

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by race, socio-economic group or geographical locations, the evidence is that a health gap still exists and is widening between the more and less disadvantaged population groups as health risks and diseases disproportionately affect those on lower income and in minority groups (Morgan & Lifshay, 2006; Marmot & Brunner, 2005).

Variations are particularly evident in places such as London where 40 per cent of the population are from visible minority communities and are also more likely to experience the harsher effects of determinants of health like unemployment, poor housing, low income and poor access to healthcare (ONS, 2001). Health inequality data for London show the adverse health among more disadvantaged populations, including lower life expectancy; higher number of years spent with disability; the lack of social support; and poorer mental health (Baker et al., 2011).

An increasing number of publications on health inequalities in the UK argue that the best way to tackle health inequalities would be to deal with the causes of inequalities which lie in education, employment and housing (Whitacre & Burns, 2010).

2.5.3. Health Policy Frameworks in the UK

Social determinants of health are influenced by national and local policies and the context to which governance, public, cultural and societal values are applied (Blas & Kurup, 2010). Several UK government policies to improve health and tackle inequalities have been developed in recent years. The *'Wanless Report: Securing Our Future Health: Taking a Long-Term View'* (Wanless, 2002) published in 2002 informed the Treasury and Department of Health on the resources required for the NHS in the next 25 years and what needed to be done to tackle health problems. Another document, '*Cross-Cutting Review on Tackling Inequalities in Health'* (HM Treasury/DH, 2002) identified five key recommendations for health action: a) breaking the cycle of poverty and inequalities; b) tackling the major public health diseases; c) improving access to health care and social services; d) empowering disadvantaged communities; and e) targeted interventions for specific groups.

The 2003 paper, *'Tackling Health Inequalities: A Programme for Action'* (DH, 2003) set out plans for tackling health inequalities by supporting families,

engaging communities and individuals, preventing disease and addressing the underlying determinants of health.

The second Wanless Report published in 2004 -'*Securing Good Health for the Whole Population'* (DH, 2004) highlighted the necessary investments that needed to be put into public health to improve roles and responsibilities, and strengthen government levers in the delivery of public health. In the same year, the government White paper, '*Choosing Health: Making Healthy Choices Easier'* (DH, 2004) supported strategies to help people make healthier choices regarding their health.

Two other important documents published in recent years included the Department of Health's update on its strategy towards reducing health inequalities by the year 2010, - '*Tackling Health Inequalities: 2006-08 Policy and Data Update for the 2010 National Target'* (DH, 2009b); and the Marmot independent review of health inequalities - '*Fair Society, Healthy Lives; Strategic Review of Health Inequalities in England post-2010'*. The latter developed a conceptual framework for reducing health inequalities (figure 2.3) by giving children the best start in life; enabling them to maximize their potential as they grow into adulthood; providing opportunities for education, training and skills for good employment; ensuring good standards of living in healthy and sustainable communities; and strengthening health promotion and protection, using evidence-based practices (Marmot et al., 2010). This review became the basis for other strategies, including the City of London's '*London Health Inequality Strategy (HIS)'* published in 2010 and '*Fair London, Healthy Londoners?'* published in 2011 (Baker et al., 2011; Greater London Authority, 2010).

This research is concerned with healthy diets, physical activity and mental health; and there were a number of policy papers in these specific areas. The NICE guidance on how to prevent, identify, assess and manage obesity advocates interventions which are sustained over prolonged periods to address diet, physical activity and support for behaviour change (NICE, 2006). The guideline outlines strategies to address barriers to changing individual lifestyle choices, including lack of knowledge about diet and exercise, cost and availability of healthy foods and exercise opportunities, environmental concerns such as safety, lack of time and low self-esteem (NICE, 2006).

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The strategy document*, Healthy Weight, Healthy Lives: A Cross-Government Strategy for England'* published in 2008, aimed at tackling obesity by reversing its trend through the creation and enabling of a healthy society from early childhood through to adulthood with emphasis on schools, food availability and access, sports and physical activities, transport and health services (DH, 2008). This was followed by a plan for getting people more physically active ahead of the London 2012 Olympics; *'Be Active, Be Healthy: A Plan for Getting the Nation Moving'* (DH, 2009). It placed the responsibility on local authorities and Primary Care Trusts to help determine and respond to the physical activity needs of their local populations, and provide and encourage physical activity at affordable costs to local communities and individuals.

These policy frameworks over the years have become drivers for several national and local initiatives to reduce inequalities and improve health, such as the *Healthy Schools Programme*; *5-a-day Programme*; *Food in Schools Programme*; *Change 4 Life Programme*; *MEND (Mind, Exercise, Nutrition…Do it!) Programme*; *Small change, Big difference campaign*; *New Deal for Communities*; *Sure Start Programme*; *Healthy Living Centres (HLC);* and *Foundation Trusts* (DH, 2010, 2008, 2005, 1999; DH/DfES, 2007).

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Figure 2.3 – Conceptual framework for strategies to reduce health inequalities in England (Source: The Marmot Review, 2010)

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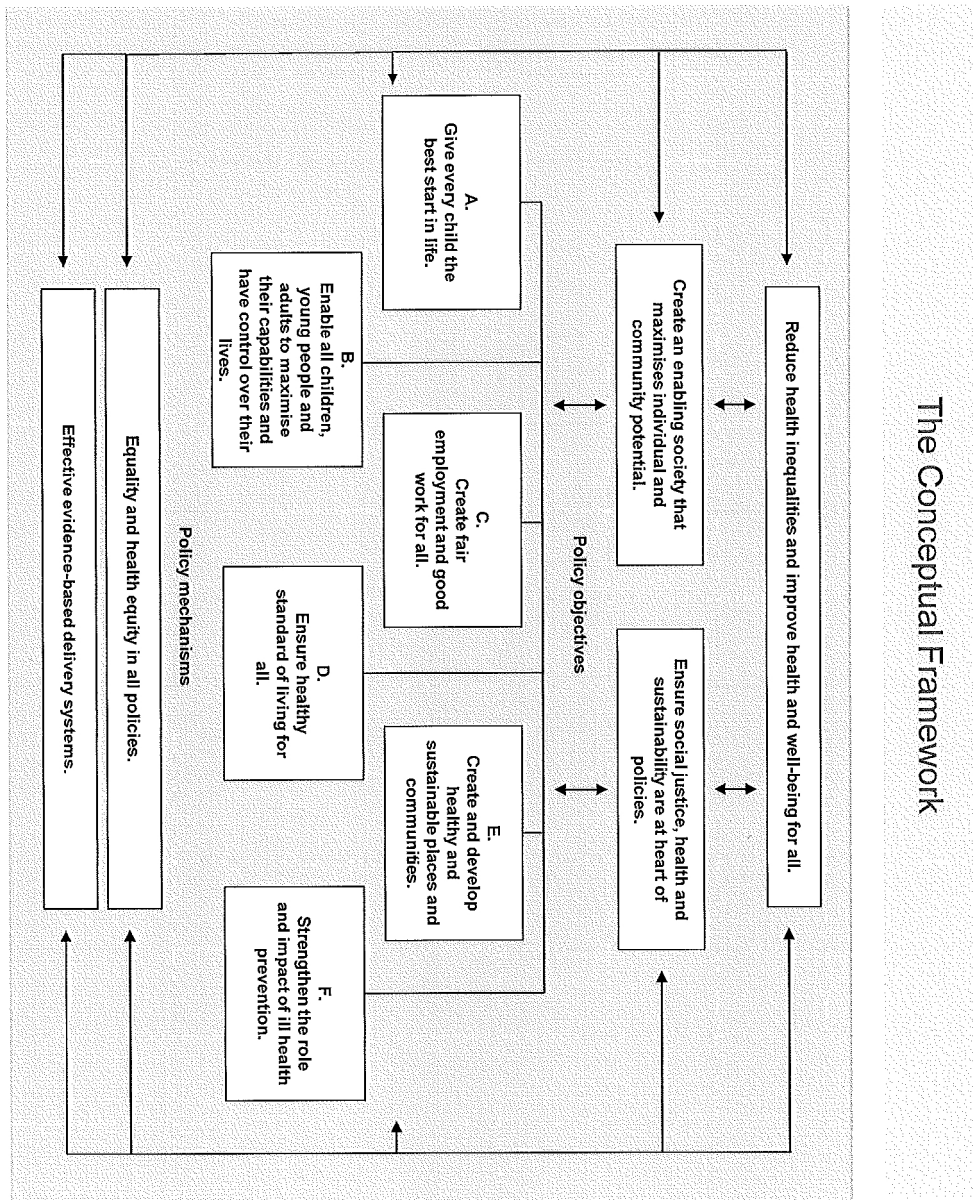
2.6. Health Promotion

Health promotion is an effective, ethical and sustainable approach to achieving and maintaining good health and a core component of public health which encourages the prevention of diseases over treatment (Davies, 2006; WHO, 1997, 2005). Health promotion refers to any activity or combination of activities which supports individuals or communities in addressing determinants of their health in order to facilitate change and become healthy (Glanz et al., 1997; Green & Kreuter, 1991; O'Donnell, 1989). Therefore, health promotion can be any combinations of social, economic, environmental, ecological, educational, organisational, legislative, regulatory and political activities which enable individuals or communities to take greater control over the factors which determine their health (WHO, 1986) based on the assumption that individuals and communities have the ability or potential undergo a positive informed change (Glanz et al., 1997). Health promotion is therefore not just the responsibility of the health sector, but all sectors involved in the provision of any of the activities mentioned above (Joint Committee on Terminology, 2001; Green & Kreuter, 1999). Consequently, health promotion activities mediate between health and other sectors, and non-governmental, voluntary and statutory sectors, making sure that health remains on the agenda of policymakers (WHO, 1986).

2.6.1. Historical Development of Health Promotion Policies

Health promotion has firmly been on the agenda of the WHO for many years, being the topic of many conferences and meetings. Various recommendations have been made through the *Lalonde Report* (WHO, 1974), the *Alma Ata Declaration on Primary Health Care* (WHO, 1978), *Health for All 2000 Strategy* (WHO, 1981), *Ottawa Charter for Health Promotion* (WHO, 1986) and subsequently the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (WHO, 1997) and the *Bangkok Charter for Health Promotion in a Globalized World* (WHO, 2005); each has built on previous recommendations and focused on widening the role of health promotion to encompass work with communities, organisations and individuals (WHO, 2009).

In 1978, the *Alma Ata Declaration* (WHO, 1978) recognised that health inequalities existed and that people and communities needed to be involved in

the process of development which could improve their lives (Laverack, 2004). Delegates to the first International Conference on Health Promotion held in Ottawa, Canada in 1986 pledged to respond to health gaps within and between societies and communities, and to tackle the inequalities in health. They also pledged to acknowledge people as the main health resource; to support and enable them to keep healthy; and to accept the community as the essential voice in the matters of its own health, living conditions and wellbeing (WHO, 1986). The conference recommended that strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems. It was vital that approaches to health promotion evolved to meet changes in the determinants of health (WHO, 1986; 1997).

The *WHO Ottawa Charter for Health Promotion* was produced in 1986, and it defined and recommended the following health promotion priority actions (WHO, 1986): building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services. For many years the Ottawa Charter has been the key policy framework of health promotion practice globally. The three basic strategies that were recognised as central to health promotion are advocacy, enabling and mediation (WHO, 1986):

i. Advocacy aims to make political, economic, social, cultural, environmental, behavioural and biological factors and conditions favourable for health by making a case for a situation or for change.

ii. Enabling aims at reducing the differences in current health status and ensuring equal opportunities and resources by ensuring equity in health, provision of a supportive environment, access to information, life skills and opportunities for making healthy choices.

iii. Mediation aims to coordinate action by governments, health and other social and economic sectors, non-governmental and voluntary organisations, local authorities, industry and the media.

The second International Conference on Health Promotion was held in Adelaide, Australia in 1988. The conference focused on the first Ottawa Charter health promotion action which is 'building healthy public policy'; the conference produced the *Adelaide Recommendations on Healthy Public Policy* (WHO, 1988). The Sundsvall Conference in Sweden in 1991 was the third

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International Conference on Health Promotion. It produced the *Sundsvall Statement on Supportive Environments for Health* (WHO, 1991) which addressed the second of the Ottawa Charter's five health promotion actions, 'creating supportive physical and social environments for health' (Laverack, 2004). The fourth International Conference on Health Promotion held in Jakarta, Indonesia in 1997 was the first to be held in a developing country and the first to involve the private sector in supporting health promotion as recognition of the importance of other sectors in health promotion. The priorities for health promotion in the 21st century were agreed by the delegates to the conference and these birthed the *Jakarta Declaration on Leading Health Promotion into the 21st Century*. The priorities for action included the following: (a) the promote of social responsibility for health; (b) increase investments for health development (c) the use of multi-sectoral approach, (d) investment in health for the particular target groups such as women, children, older people and the indigenous poor and marginalized populations; (e) consolidate and expand partnerships for health; (f) increase community capacity and empowerment of the individual; and (g) the safeguard the infrastructure for health promotion (WHO, 1997). Some core elements for successful health promotion interventions which are relevant to all countries were also identified (WHO, 1997):

a. Comprehensive approaches to health development are most effective. Health promotion interventions that use the combinations of the five Ottawa charter strategies are more effective than single-track approaches.

b. Target settings which offer practical opportunities for the implementation of comprehensive strategies such as mega-cities, islands, municipalities, local communities, markets, schools, workplaces and healthcare facilities.

c. Participation is essential to sustain efforts and people have to be at the centre of health promotion actions and decision-making processes for them to be effective.

d. Access to education and information is vital to achieving effective participation and the empowerment of people and communities because health-learning fosters participation.

e. Cooperation is essential and requires the creation of new partnerships for health between different sectors and at all levels of governance in societies.

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The fifth Global Conference on Health Promotion was held in Mexico in 2000, and had the theme 'Health Promotion: Bridging the Equity Gap'. This conference produced the *Mexico Ministerial Statement for the Promotion of Health: from Ideas to Action* (WHO, 2000). Some key actions contained in the action framework were (a) the support of research to advance knowledge on the priorities identified in health promotion, and (b) the mobilization of resources and capacity building for development, implementation and evaluation of national strategies to promote health (WHO, 2000; 2009). The sixth International Conference on Health Promotion was held in Bangkok, Thailand in 2005. This conference produced the *Bangkok Charter for Health Promotion in a Globalized World* (WHO, 2005) which recognised that the global context for health promotion had changed significantly since the *Ottawa Charter* in 1986 due to very important changes which have considerable impact on health such as the increasing inequalities within and between countries; new patterns of consumption, communication and commercialisation; changes in the global environment and urbanization. Other factors such as demographic changes, changes in family patterns, working conditions, learning environments and social communities were also recognised as new considerable effects on the determinants of health (WHO, 2005). These challenges called for new commitment to tackling the determinants of health, and the conference produced the *Commitments to Health for All* (WHO, 2005) which included key commitments to make health promotion a core responsibility of all local, regional and national governments, and to focus on achieving sustained community empowerment and engagement.

The seventh and most recent Global Conference on Health Promotion with the theme 'Promoting Health and Development: Closing the Implementation Gap' was held in Nairobi, Kenya in 2009; it produced *the Nairobi Call to Action for Closing the Implementation Gap in Health Promotion* document which looked at how health and development had been affected by recent global issues such as the global financial crises, security threats in many regions of the world, global warming and climate change (WHO, 2009).

2.6.2. Health Promotion Approaches and Theories

The five main approaches to health promotion are: a) medical approach; b) behavioural or lifestyle approach; c) educational approach; d) client-centred

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approach; and e) the socio-environmental approach (Laverack, 2004; Ewles and Simnett, 1999; Downie et al). The medical approach is expert-led, top-down approach and concerned with the treatment of diseases, while the behavioural or lifestyle approach focuses on health education and individual high-risk behaviours; the socio-environmental approach however recognises that health education alone will not change behaviour and that socio-economic, environmental and cultural factors have bigger impacts on the health of individuals and communities. (Ewles & Simnett, 1999; Downie et al, 1996; Labonte, 1993).The differences in the approaches is that the medical and behavioural approaches target high-risk individuals and groups while the socio-environmental approach targets high-risk conditions such as poverty and poor environmental conditions (Laverack, 2004; Ewles and Simnett, 1999; Downie et al, 1996; Labonte, 1993).

The practice and science of health promotion is based on models and theories of change (O'Donnell, 1989). These theories attempt to explain the processes underlying learning, while models represent them (Glanz et al, 2002; Raeburn & Rootman, 1998; Gold et al., 1997; Green & Kreuter, 1992; Chaplin & Krawiec, 1979). In health promotion, theories can be used to explain different aspects of change at individual, community and organisational levels, and help to achieve a better coordination between a health problem and a health promotion programme that will address the problem (Nutbeam & Harris, 2004). Three groups of theories that have been identified are:

1) Theories that explain individual health behaviour and health behaviour change, for example health belief model (Becker & Rosenstock, 1987; Becker, 1974; Rosenstock, 1966); theory of reasoned/planned action (Ajzen, 1988; Fishbein & Ajzen, 1975); transtheoretical or stages of change model (Prochaska & DiClemente, 1982); and social learning (cognitive) theory (Bandura, 1995, 1977).

2) Theories that explain community health and changes in community health through community action for change, such as community mobilisation (social planning, social action, community development); diffusion of innovation (Nutbeam & Harris, 2004).

3) Theories that explain organisations and the changes in organisation which promote health-supportive organisational practices, for example

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organisational change models of intersectoral action (Nutbeam & Harris, 2004).

2.6.3. The Role of Research in Health Promotion

Health promotion research has been identified as an integral part of the practice of health promotion because it helps to define and evaluate health promotion practices and theories (Watson & Platt, 2000); answer the relevant questions about what works, in what circumstances and with whom (Health Education Board for Scotland, 1999); develop critiques of health promotion practice, or the study of the values and basis of policy and practice (Nettleton & Bunton, 1995; Thorogood, 1992). Documentation of experiences in health promotion through research and project reporting also help to enhance and improve planning, implementation and evaluation of future health promotion interventions (Watson & Platt, 2000). It is the evidence derived from health promotion research which provides the evidence base for health promotion strategies, informs the development of education, policy, legislation and regulation which prevent diseases and injuries (WHO, 2009).

However, health promotion has not traditionally been effective at addressing inequalities in health because it had been normative and practiced under the assumption that giving information through health education will necessarily lead to behaviour change (Duncan & Cribb, 1996). Health promotion practices are unlikely to be successful if they only provide information and fail to engage with the way of life of people and the social determinants of their health (Nutbeam & Harris, 2004). For instance health education about diet or nutrition is likely to be ineffective if the essence of food choices such as cultural or social significance is not recognised (Burch, 2008; WHO, 2005; 1998). Evidence suggests that health promotion has in fact improved health but largely of the affluent population sub-groups; it has remained largely unsuccessful in disadvantaged areas particularly where no community engagement is in place (DH, 1999).

Therefore in recent years, there have been repeated calls for more research and evidence in health promotion and the factors that support the successful implementation of health promotion programmes (NICE, 2006). Some for example, argue that concepts such as 'social capital' become increasingly

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important in understanding how health promotion in communities takes place and how health outcomes are influenced through social cohesion, status and self-esteem (Daykin & Jones, 2008; Wallerstein, 2006; Marmot, 2004; Williams, 2003; Portes, 1998; Putnam, 1995; Bandura, 1994; Bourdieu, 1984; Durkheim, 1952). A number of authors in recent years argued that research and case studies in health promotion are crucial, but there is need to develop a system for dealing with findings from multi-level, multi-method perspectives to demonstrate the impact of health promotion at individual, organisational and community levels (Watson & Platt, 2000). Brannstrom and colleagues (1994) developed a framework to assess the outcomes of community-based interventions by using a multi-method approach for outcome assessment of individual and community change, which included the following elements: a) assessments of community participation; b) socio-epidemiological study; c) key informant study; d) content analysis of mass media; and e) description of social, cultural and political change (Brannstrom et al, 1994).

This study also used a multi-method approach and looked at health promotion interventions from multiple perspectives.

Chapter 3 – Literature Review: Community Engagement for Health Promotion

3.1. Introduction

This chapter reviews literature on community engagement with a specific focus on its role in health promotion. It looks at the importance of community engagement in health promotion theory and practice; different models and approaches to involving communities in the design and delivery of health promoting interventions; and the evidence of the incentives, barriers and benefits of community engagement. This review aims to understand the current framework for community engagement in the design and delivery of health promotion interventions to communities, and looks at the models and approaches used in the last 25 years (since 1986, the year of the adoption of the Ottawa Charter); and some more recent policy frameworks around community engagement in the UK.

The literature search was done electronically using the University of East London (UEL) electronic Library and Learning Services website and UEL Catalogue, and other internet-based journal databases. Keywords used in the search were: community, community participation, community involvement; community engagement; theories and approaches to engaging communities; impact of community engagement. The search was limited to 1986 to 2009 at first, and then updated with more recent publications from 2010 and 2011. Access to electronic journals was through Athens and EBSCOhost online engines. Grey literature was searched through the websites of the UK Department of Health, National Institute for Health and Clinical Excellence, Office of National Statistics, Department for Communities and Local Governments, and Google® and Google Scholar® databases.

3.2. Communities and Their Needs

There are various definitions of the term 'community', which reflect the differences in community types, experiences, and memberships (MacQueen et

al., 2001; Campbell & Jovchelovitch, 2000). A community can refer to any group of people who share common characteristics such as their geographical location (estate, ward, street, village, or town); culture or subculture (such as their ethnicity, age-group, disability, sports interest, occupation, faith); or other shared interests or common bonds (such as political affiliation, enterprise or profession) over a period of time (Tropman et al., 2006; Putnam, 2000). Indeed, community is not static and one or more communities may exist within a larger one or there may be overlapping memberships across different communities (Tropman, Erlich & Rothman, 2006; WHO, 1998).

The common use of the term 'community' as a geographic connotation does not usually take into account variations in social, economic and cultural circumstances of the people living in that community, but assumes a general sense of identity, harmony and inclusiveness which could be misleading (Head, 2007). Back in the late 1880s, Ferdinand Tönnies
 (1887) differentiated between the terms 'society' and 'community'; he described community as a cohesive kinship formed as a result of unity of will due to shared goals, interests or characteristics; while society was a larger collection of people with different goals and interests, and more emphasis on individual needs (Tönnies, 1887/2001). Although most human interactions are based on a combination of these two entities, interactions of the community type are deemed more beneficial (Tönnies 1887) as these interactions have spatial and non-spatial dimensions, and focus on identification of shared needs and concerns (Laverack, 2004).

Community is characterised by membership and sense of belonging; this identity is gained through shared beliefs, values and norms (NICE, 2008; Putnam, 2000; WHO, 1998; McMillan & Chavis, 1986) and common representative features such as language, rituals, ceremonies, mutual influences, commitments, and emotional connections (Petersen, 2007; Putnam, 1995; Israel et al, 1994; McMillan & Chavis, 1986). The sense of belonging to a particular community or communities is usually strong; for example, studies in the UK suggest that three quarters of people in the country have strong feelings of belonging to their local communities (Communities and Local Government, 2008). Communities share locations, issues and identities, and therefore often have common needs which affect them collectively or as individuals (Morgan

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& Lifshay, 2006); they also have a commitment to meeting these needs (WHO, 1998). A community need could be a problem or a requirement for action; and may be relative to what is possible based on social definitions and past experiences (Sen, 1999). Examples of community health needs include social care, housing, income, education, employment, recreation, transport and access to services (Asadi-Lari et al, 2003).

Public health specialists have traditionally defined public health priorities through assessments of community needs. For example, the control of communicable diseases in the 20th century was achieved through effective mass mobilization for immunization, sanitation and hygiene (Morgan & Lifshay, 2006). However, it is important to differentiate between normative and true community needs. The former is usually what professionals think the community needs and may not involve any active community role (Morgan & Lifshay, 2006); the latter is a self-identified community or individual need (Bradshaw, 1972) which is expressed through community engagement processes (Minkler & Wallerstein, 2002). Identifying collective needs requires deliberation, which is a critical component of a local community health needs assessment and a primary method of democratic engagement with the public (Clark et al, 2003; Simpson, 2001). It ensures a two-way communication (Kotter, 1996), an engaging dialogue, and local buy-in (Gravenkemper, 2007).

Academic literature identifies various reasons for involving communities in the identification of their needs. Some scholars argue that due to the limited resources available, it is important that communities are involved in the identification of the most urgent priorities (Glanz et al, 1997; Parsons, 1995; Miller, 1985). McBride and Korczack (2007) noted that the community ought to be consulted on how public money is spent because they are the taxpayers who contribute to the government's purse (McBride & Korczack, 2007); while Scutchfield et al. (2006) emphasised the ethical principles of public health which require a certain level of public engagement in priority-setting, development and evaluation of programmes (Scutchfield et al, 2006). Kurland (2002) noted that public health is most effective when information is broadly disseminated and understood, benefits and costs are debated, decision-making is shared by those affected, and public interest is seen as more valuable than private gain (Kurland, 2002). McKnight & Kretzmann (1997)

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argued that communities face a multitude of interdependent problems such as illiteracy, gangs, unemployment, boarded-up houses, child abuse, homelessness, abandonment, dropouts, pollution, AIDS, alcoholism, welfare dependency, domestic violence, pests, mental illness, slum housing, crime, drug abuse, teenage pregnancy, truancy and broken families (McKnight & Kretzmann, 1997; Kretzmann & McKnight, 1993) which usually have similar root causes, co-existing and interplaying with one another, and presenting a complex community challenge which requires joint community assets, resources and skills (Duncan, 2002; Mathie & Cunningham, 2002; McKnight & Kretzmann, 1997). And as most of these complex issues are rooted in social problems, communities are better placed to identify and resolve such problems, and therefore address their health needs (Scutchfield et al, 2006).

3.3. Community Engagement: Understanding and Rationale

Community engagement is an umbrella term which implies the public's involvement in determining how society steers itself, makes decisions on public issues, and delivers programmes for the benefit of the people (Patel et al., 2002; Health Canada, 2000; Zakus & Lysack, 1998; Checkoway, 1989).

The data on public engagement in decision-making varies by context and between communities. In the UK for example, only 39% of people feel they have an influence over decisions affecting their communities, and only 23% feel they can influence issues that shape the country (Communities and Local Government, 2008). There are variations between different sub-population groups; for example, White people in the UK feel they are less able to affect decisions in their communities and the country than people from Black and minority ethnic communities (Communities and Local Government, 2008). Engagement of people in public activities may also vary. In the UK, only around 36% of people participate in community activities such as public meetings, signing petitions or contacting a local councillor (Communities and Local Government, 2008).

In the health field, community engagement is viewed as an approach for reducing inequalities and promoting health and wellbeing, especially in

disadvantaged groups (NICE, 2008; Butterfoss et al., 1996). It is believed that community engagement leads to public services that are more responsive and tailored to the needs of the communities and helps to involve people who are disenfranchised and disengaged from other forms of civic engagement (DH, 2006). It also builds social capital and mutually supportive relationships between people who live in close proximity, have similar interests or share same life circumstances (Neighbourhood Renewal Unit, 2003; CDC, 1997; Fawcett et al., 1995).

Community engagement encompasses a range of methods and approaches to get communities involved through creating opportunities for identification of local needs, building genuine partnerships, and supporting active and inclusive participation (Tamarack, 2007; Patel et al., 2002; Zakus & Lysack, 1998; Checkoway, 1989). When communities pull their efforts and resources together to increase their control over the determinants of their health in order to improve their health, this is referred to as 'community action for health' (Putnam, 2000). Such action requires social networks and begins with the identification and articulation of community needs which is achieved through community engagement (WHO, 1998).

Community engagement is now mainstream policy within the statutory sector in the UK (Taylor, 2007; Carpini et al., 2004); but there is increasing evidence that communities, especially the most deprived ones, are experiencing consultation fatigue and are becoming sceptical about the process being a mere rubber-stamping exercise (Communities and Local Government, 2008). A number of approaches have been developed to overcome this and scholars have advised that focus should be on better understanding the processes and impacts of community engagement on communities and services they receive (Kagan, 2006).

3.4. Empowerment as a Theoretical Framework for Community Engagement

This study as well as the Well London (WL) community engagement process (CEP) itself, has been grounded on the theories of empowerment.

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3.4.1. Historical and ideological perspectives on empowerment

Empowerment is a construct that is found and used in multiple fields and disciplines, including community psychology, community development, community planning, public health, sociology, philosophy, organisational management, policy analysis and social sciences; and the definitions of empowerment vary broadly (Wallerstein, 1993; Rappaport, 1981). However, across the spectrum of multiple definitions and meanings, there is a consensus that empowerment is both a process and an outcome (Table 3.1), and can be manifested at both individual (psychological) and community levels (Zimmerman, 2000; Wallerstein, 1992; Swift & Levin, 1987).

Historically, the concept of empowerment has grown from the theories of power and the struggle for power dating back to the works of key power theorists such as Karl Marx, Max Weber, Michel Foucault and Robert Dahl (Sadan, 2004). Karl Marx conceptualised power within the social structure and its relation to economics (Marx, 1844). In the 20th century, Max Weber made important connections between power and government as a bureaucratic structure which made decisions that affected society, and noted the domination of economic and social relations in the distribution of power within society (Weber, 1968, 1947, 1946). Michel Foucault studied the complex relations between knowledge and power; he agreed with Weber that power was a relational concept and further stated that it was not completely embedded in the government but was exercised throughout the social structure (O'Farrell, 2005; Gordon, 1980; Foucault, 1972). Weber's social power structure was explained in the context of a community setting by Robert Dahl (1961) from the viewpoint of power exercised by the privileged few over other members of the society because of their economic superiority (Dahl, 1961).

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Table 3.1 – Definitions of empowerment as a process and an outcome

Empowerment as a Process	Empowerment as an Outcome
➢ *Process of re-negotiating power in order to gain more control (Baum, 2008)* ➢ *Process by which people gain control over the factors and decisions that shape their lives… process by which they increase their resources, power and competence; and gain access, partners, networks and/or a voice (Labonte, 2008)* ➢ *Process of struggle and liberation associated with gaining power and control over decisions which affect the community's determinants of health (Laverack, 2007)* ➢ *Social action process for people to gain mastery over their lives and lives of their communities in order to make social and political environments favourable for equity and good quality of life (Glanz, Lewis & Rimer, 1997; Wallerstein, 1992; Rappaport, 1984)* ➢ *Fostering participatory competence in the political life of the community (Florin & Wanderman, 1990; Kieffer, 1984)* ➢ *An active process…. (Zimmerman & Rappaport, 1988)* ➢ *Social action process that promotes participation of people who are powerless towards goals of increased decision-making and control, equity of resources and improved quality of life (Wallerstein, 1986)*	➢ *Acquisition of different forms of power (Laverack, 2008)* ➢ *Community ownership (Baum, 2008)* ➢ *Assumption of greater power to create desired change (Glanz, Lewis & Rimer, 1997)* ➢ *Changes in policies; changes in living conditions; increased resources; reduced inequities (Glanz, Lewis & Rimer, 1997)* ➢ *The "Holy Grail" of health promotion (Rissel, 1994)* ➢ *Access to social, economic and political resources (Friedman, 1992)* ➢ *Capacity to identify problems and solutions (Braithwaite et al., 1989; Cottrell, 1983)* ➢ *… Outcomes of self-acceptance, self-confidence, greater understanding of social and political structures and issues, civic commitment; ability to take part in decision-making and democratic processes, and control over local resources (Zimmerman & Rappaport, 1988)* ➢ *Interactions that lead to changes in social structure (Israel, 1985)* ➢ *Communities achieving equity (Katz, 1984)*

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In the 1980s, a number of theorists emphasised a relationship between power and social exclusion, arguing that the lack of power of certain groups notably those in low socio-economic groups, excluded them from decision-making and mainstream society and perpetuated social inequalities (Wallerstein, 1993; Mann, 1986; Gaventa, 1980). This exclusion was explained as refusing the excluded group the right to participate on equal terms in social relations and decision-making (Khan, 2009; Gaventa, 1980). This suggests that a dominant group in the society have the power to label and exclude another (Moncrieffe, 2007), thereby making them more powerless and disadvantaged, and putting them at risk of ill-health, since the lack of control over one's circumstances is a causative factor for disease (Wallerstein, 1992).

There are a number of mechanisms through which social disadvantage leads to disempowerment and vice versa. In essence, socially disadvantaged groups lack opportunities and resources to influence decisions determining their environments and lives; this disempowerment in turn can further exclude these groups from accessing resources they need to change their socio-economic circumstances (Sadan, 2004; Parsons, 1995; Rappaport, 1981).

A number of earlier theoretical and empirical works tried to establish the sources of powerlessness at the individual and community levels. Mann (1986) pointed to isolation and marginalisation, which lead to inability to establish alliances to challenge authorities. He further noted the lack of cohesion or integration which divides people in a community and keeps them apart, preventing them from forming alliances. Another crucial source of powerlessness is the lack of knowledge about what the issues are and how they can be addressed (Mann, 1986). Foucault (1972) was of the opinion that knowledge is power; and that power and knowledge are complexly linked (Foucault, 1972). Paulo Freire (1973) pointed to education as a way of acquiring knowledge and hence power. He and a number of authors believed that education, including the possession of information, communication and debates bring about a critical consciousness which leads one to question the status quo and existing power structures (Wallerstein, 1993: Wallerstein & Bernstein, 1988; Freire, 1973), and enables people to engage in the political processes which can bring about desired change (Freire, 1973).

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Different views on and theories of empowerment have been historically determined by the ideological perspectives one takes in considering the sources of power and powerlessness. Ethnocentric approach, for example, addresses disempowerment stemming from ethnicity, religion, or other factors that determine minority groups (Gutierrez & Ortega, 1991; Gutierrez, 1990; Solomon, 1976). A conservative liberal approach seeks to address disempowerment through the strengthening of facilitating structures such as schools, neighbourhoods, families and community organisations, and to restore social units which can take care of those who are less able (Berger & Neuhaus, 1977); the socialist approach looks at empowerment through the fight for equity, social justice and responsibility (Boyte, 1984); while the democratic approach is based on the rule of law and legitimate social ideology where people are expected to have a say in the issues that concern them and their communities (Rappaport, 1987; 1981).

The impetus for empowerment is the desire for change; and the outcome of empowerment is a change, and this change can take place at an individual or community level, or both (Zimmerman, 2000). The basis for wanting a change is usually socio-economic, including inequalities, marginalisation, vulnerability, or lack of social justice (Perkins & Zimmerman, 1995). As power is the underlying commodity of empowerment, it leads to a dualism of "powerful-powerless" identities; and the intended change is also usually power-related (Baum, 2008; Labonte, 2008; Pease, 2002; Foucault, 1973). Empowerment is therefore often associated with changes in who holds power with an increase of power in one group and a decrease in another one (Labonte, 2008; Laverack, 2006; Schuftan, 1996; Gutierrez, 1990; Clegg, 1989; Gaventa, 1980), although empowerment is not characterised as achieving power to dominate others, but rather, power to act with others to effect change (Wallerstein & Bernstein, 1988). However, some authors argue that power is not a zero-sum commodity where one party has to lose it for another one to gain it. They believe that empowerment can be a win-win situation (Checkoway, 1995; Swift & Levin, 1987).

Empowerment as a post-modern ideology emphasises subjective perceptions and knowledge as social constructs (Sadan, 2004; Pease, 2002; Foucault, 1973). It questions the reality of what exists and the powers that be; empowerment

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suggests a struggle to change the status quo (Israel, 1985; Marx, 1844). Goals, aspirations and evaluations are based on what a particular social group believes them to be, therefore, even though there are commonly shared characteristics of empowerment irrespective of a social context, cultural relativism suggests that empowerment may vary within different communities due to the relative interpretations of it (Christens et al, 2011; Best & Kellner, 1991).

Some recent literature looked at challenges to empowerment and argued that some of the key issues around empowerment lie in the modern community structures and characteristics of urban neighbourhoods which lack the relationships and emotional bonds present in communities in the past; new urban neighbourhoods do not support a community where interactions take place and alliances are made (Atkinson, 2008; Parkinson, 2005; Davis, 1991). There is empirical evidence to suggest that these challenges can be dealt with by forming alliances around common issues of interest which can help mobilise community members and build links between them; this can in turn bring the feeling of unity around other issues other than the fact that they live in the same neighbourhood (Atkinson & Carmichael, 2007; Atkinson & Eckardt, 2004; Davis, 1991).

3.4.2. Process and outcomes of empowerment – links to community engagement

The process of empowerment begins with community awareness of an issue, followed by community engagement and community organising (Tamarack, 2003; Fawcett et al., 1995). One of the most critical steps which determine the success of community empowerment is the careful selection of the issue around which the community is mobilised (Fawcett et al., 1995). It is important to realise that the communities may experience problems, but they themselves are not the problems (Kriger, 2007). Also, not all problems in the community are issues the community feels strongly about or deeply affected by. The issue needs to be uncomplicated and specific and every member of the community should be able to describe the problem and how it affects them. It should also be the problem that affects all members or a large proportion of the community at least (Glanz et al, 1997; Miller, 1985).

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Once an issue has been selected, the next step is to increase awareness of that issue. It is at the stage of community awareness that the community reflects and consciously become aware that they are powerless (Glanz et al, 1997). Community awareness requires good communication so that the people feel encouraged to discuss and debate the issue. Community awareness increases knowledge and awareness, and helps to encourage critical thinking around the influences that operate locally (Freire, 1973). Communities should be able to take stock of community resources, assess strengths and weaknesses, and identify strategies available for their empowerment (Wallerstein, 1993; Couto, 1989).

Empowerment utilises partnerships and coalitions with a variety of stakeholders, including community non-profit organisations, government agencies and private sector organisations which add to resources available to local residents for increasing their power and assets (Fawcett et al, 1995; McMillan et al, 1995; Rich et al, 1995; Speer & Hughey, 1995).

The outcomes of empowerment are the benefits accrued from the process of empowerment, and the most important outcomes are the transition of power and control to the communities; reduced dependency on professional services; democracy; accountability; sustainability; resilience and social cohesion; ability to effectively deal with complex problems through the skills and knowledge acquired during empowerment; and increased network of partners (Laverack, 2008; Glanz et al, 1997; Fawcett et al, 1995; Speer & Hughey, 1995). Empowered communities are also characterised by political openness; strong leadership and a good relationship between the community's formal and informal leadership (Zimmerman, 2000).

Community empowerment is both political and psychological, being a socio-political action (community participation) which leads to psychological change (empowerment); and the outcomes of empowerment could be perceived at both subjective and objective levels (Zimmerman, 2000; Wallerstein, 1993; Bandura, 1989). It aims to collectively and collaboratively grapple with those shared social problems that the individual alone cannot deal with, to achieve the shared goal of an improvement in the quality of life of the community and its members (Wallerstein, 2002). An empowered community is one in which individuals and groups apply their skills and resources in

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collective efforts to meet their respective needs (Israel et al, 1994). Subjectively, individuals or communities may perceive that they are better able to control the influences on their lives through acquisition of skills and improved self-esteem and self-confidence; this is psychological empowerment (Perkins & Zimmerman, 1995; Zimmerman et al., 1992; Bandura, 1989; Kieffer, 1984). Objectively, an individual or community performs activities that influence their life and local environment and achieves some form of social change (Zimmerman & Zahniser, 1991). Objective empowerment activities include contacting elected officials or public officials concerning issues in the community, attending meetings and expressing opinions, signing petitions, becoming members of local advisory committees, school governors or even running for elected positions (Stewart, 1996; Biegel, 1984). Table 3.2 below shows some of the characteristics of subjective and objective states of powerlessness and empowerment.

Table 3.2 – Subjective and objective features of powerlessness and empowerment

State of powerlessness	State of empowerment
Subjectively: ➢ Helplessness ➢ External locus of control ➢ Alienation and isolation *(Rotter, 1990; Maier & Seligman, 1976; Rotter, 1971; Seeman, 1959)*	Subjectively: ➢ Assertiveness ➢ Social and political understanding ➢ Perceived ability to control ➢ Belief and motivation that change can/will occur *(Wallerstein, 1993; Zimmerman & Rappaport, 1988; Kieffer, 1984)*
Objectively: ➢ Lack of economic and political resources ➢ Poverty ➢ Powerlessness ➢ Dependence *(Albee, 1981; Gaventa, 1980)*	Objectively: ➢ Participation for social change ➢ Equity and access ➢ Capacity to make decisions and solve problems ➢ Control over determinants of health *(Chavis & Wandersman, 1990; Braithwaite & Lythcott, 1989; Zimmerman & Rappaport, 1988;HHealth Promotion, 1986; Naparstek et al., 1982)*

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Empirical studies have pointed to community empowerment resulting from community engagement through the processes of capacity building, acquisition of skills and knowledge, building social capital and community cohesion, achieving positive change for the community, and speaking as a united community with one voice (Goodlad et al., 2003; Cairncross et al., 2002; Tunstall, 2001).

3.4.2. Empowerment as a Theoretical Framework of this Study

This study looks at community engagement as a means of achieving community empowerment based on social constructivist paradigm that community engagement and community participation are precursors of empowerment (Christens et al., 2011). It investigates the mechanisms through which engagement in community activities impacts on health and wellbeing of residents. It also looks at whether and how communities exercise power and influence over local health-related interventions.

The concepts of empowerment and health promotion are closely linked as empowerment plays an important role in supporting people to gain control over the influences in their lives and local environment (Labonte, 2008; Laverack, 2008; Zimmerman et al., 1992; Kieffer, 1984). Furthermore, policy-level health promotion actions help to build a social change which breaks the vicious circle of social and economic disadvantage which lead to poorer health outcomes and health related inequalities (WHO, 2009; Bandura, 1989).

For the purpose of this study, the definition of empowerment reflects both the processes and outcomes of empowerment, and focuses on people as the key actors of the empowerment process (Perkins & Zimmerman, 1995; Wallerstein, 1992; Braithwaite et al., 1989; Rappaport, 1984; Cottrell, 1983). The key assumption of this specific study is that empowerment is a process and an outcome of a set of actions that people undertake in shaping and improving the health of their communities through being motivated to actively participate and engage in community activities which support them to identify needs, proffer solutions, and gain capacity and skills to achieve a social change in their environment through improved equity and quality of life; and which leads them to have pride in their neighbourhood.

The diagram below shows the assumed logical sequence and relationship between community needs, engagement and empowerment, which represents the conceptual framework of this study. It suggests that an ability to express concerns and needs about an issue, followed by an effective engagement in finding solutions, leads to power shifts and empowerment of those engaged. This study is an empirical testing of this model which examines the mechanism through which engagement challenges the existing power paradigms, the resources and assets; the processes through which the empowerment takes place, and the outcomes of empowerment as manifested in the communities researched.

Figure 3.1 – Community empowerment framework for this study

Good Issue Selection
- Specific and simple
- Winnable
- Involves and unites residents
- Community feels strongly about issue
- Frequently expressed issue which already has inertia
- Affects a majority of the residents

Effective Community Engagement
- Effective local research to get to know community
- Selection and involvement of appropriate local community organisation (Entry)
- CEP (Community Cafe; Community Action Workshop; Project Implementation Meeting)
- Sufficient time to build relationships

Community Empowerment
- Actively engaged and motivated residents
- Equity
- Capacity to identify problems and issues
- Increased influence and power shift
- Social action
- Improved key social indicators

This research looks at diet, physical activity and mental wellbeing as the three community issues around which the WL CEP was organised. It examines the processes through which the identification of these issues and potential solutions took place; the mechanism which led to or prevented an increased community power; the characteristics of the CEP, what facilitate or undermined the process of empowerment; and intervention and community features through which empowerment manifested.

As empowerment is a subjective and relative construct, it is worth remembering that the evaluation of its impact is never rigid (Wallerstein, 1993). The degree of empowerment a community achieves depends on the background, the history and past experiences of empowerment in the community; the setting and circumstances; and the motivation, behaviours, attitudes and knowledge of the residents (Zakus & Lysack, 1998; Fawcett at al., 1984). Therefore, the conceptual framework of this study should be considered with the adjustment for constructivist perspectives on knowledge in multiple ways depending on the situational circumstances (Spiro et al., 1995). This cognitive flexibility approach helps to understand multiple situations and a variety of contexts (Graddy, 2001). The major goal of cognitive flexibility is to help develop the ability to transfer and restructure knowledge in different circumstances and as needed, especially where change occurs (Graddy, 2001).

Figure 3.2 – Cognitive flexibility modified by background circumstances
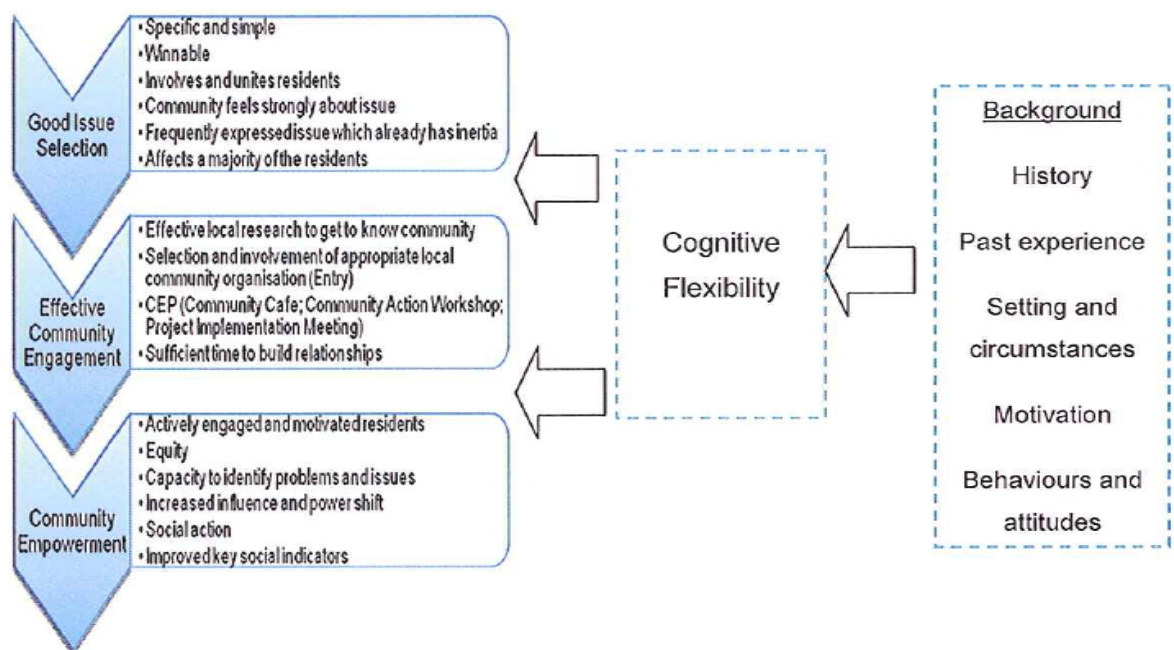
3.5. Levels of Community Engagement

Academic literature encompasses extensive debates on the different terms and concepts used to describe community engagement. Some of the most frequently used terminologies include community consultation, community participation, community involvement and community development. Although

some literature use all or some of these terms interchangeably, others distinguish between different levels at which engagement takes place and subsequently different levels of empowerment the community experiences (Popay et al., 2007)

Thus, a number of scholars view community engagement as a dynamic process of reciprocal exchange of information, ideas and resources between community members and external organisations, with increasing levels of engagement ranging from passive to reactive, through to participative, empowerment and leadership by communities (figure 3.3) (Popay, 2006; Sydney Department of Planning, 2003; Hashagen, 2002; Arnstein, 1969). Popay (2006) described increasing community engagement ranging from informing through consultation, co-production, to delegated power and community control (Popay, 2006). At the lowest level is the provision of information to the community through means such as community newsletters and public notices (Popay, 2006; Hashagen, 2002). The next level (consultation) requires the provision of information but also a request for feedback from the community through methods such as questionnaires, surveys, focus groups, panels and juries; the community is at a reactive stage at this point (Hashagen, 2002). The community only becomes active at the third level of engagement where there is actual involvement in the identification of their needs based on their perspective through methods such as involvement in community planning groups, advisory and management committees (Hashagen, 2002; Arnstein, 1969). Higher levels of participation are achieved through community partnership working and campaign or pressure groups (Hashagen, 2002; Arnstein, 1969). It is at the higher levels of engagement that empowerment occurs, and social and structural changes happen to redress the power relations that perpetuate health inequalities (Laverack, 2005).

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Figure 3.3 - Levels of Community Engagement. *Source: Adapted from; Popay, 2006; International Association for Public Participation (IAP2) (2004); Hashagen, 2002; Arnstein, 1969)*

PASSIVE (Informing)	REACTIVE (Consultation)	PARTICIPATIVE (Co-production)	EMPOWERMENT (Delegation of Power)	LEADERSHIP (Community Control)
Community residents and organisations are informed of issues by external organizations or statutory organisations →	Community residents and organisations give input into the priorities and use of resources of external organisations →	Community residents and organisations influence the priorities and use of resources of external organisations →	Community residents and organisations work in partnership to plan and implement action with external organisations →	Community residents and organisations initiate and lead in setting priorities, planning and implementing action, with the support of external organisations →

Levels of Community Engagement

[Increasing Level of Public Impact]

One of the most frequently used terms to describe community engagement is community participation (Tindana et al., 2007). This term is commonly used in the academic literature but does not always mean the same thing to different authors (Oakley, 1989). It is therefore essential to look at community participation as a separate process of engagement. Community participation is often viewed as a creation of democratic opportunities for communities (National Empowerment Partnership, 2008) based on the assumption that important decisions in society are within the capabilities of ordinary citizens (Zinn, 1990). From the theoretical perspective, participation is way of socialisation in a community which enables individuals acquire the characteristics of the group (Petersen, 2007; Putnam, 1995). From the practical perspective, community participation means the involvement of people in the analysis, decision-making, and programme planning and implementation stages; as evidence suggests that people are most committed to implementing projects that they have helped to plan (Rifkin et al, 2000).

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Although most literature suggests that there is a relationship between community participation and empowerment (Russel et al., 2009; Itzhaky & York, 2000; Booker et al., 1997; Gutierrez, 1995; Rich et al., 1995; Schulz et al., 1995; Israel et al., 1994; Zimmerman et al., 1992; Chavis & Wanderman, 1990), the nature of this relationship is debatable. Some authors argue that participation in decision-making and implementation is a key component of empowerment and acts as a building block on which community activities are set, such that when residents participate in community activities, there is a sense that they expect that their involvement will make a difference; and that in itself is an empowering notion of perceived ability to control or influence factors in the environment (Arnstein, 1969). Some other scholars suggest that higher levels of participation lead to empowerment largely through the process of socialisation (Christens et al., 2011; Ohmer, 2007; Peterson & Reid, 2003; Itzhaky & York, 2000; Markham & Bonjean, 1995). Others however suggest that empowerment precedes community participation through the process of selectivity, where people choose to participate in activities for which they perceive they have the skills and resources to be successful (Bekkers, 2005; Cohen et al., 2001; Verba et al., 1995; Bandura, 1989). Other authors emphasise bidirectional reciprocity between participation and empowerment where one process facilitates the other (Speer & Hughey, 1995; Chavis & Wanderman, 1990; Kieffer, 1984).

Some authors argue that participation in community could be direct or social; direct participation involves the implementation of projects through the mobilisation of the community resources, while social participation is where the community decides and therefore takes control over factors that control their health (Muller, 1983). Some suggest that participation can be marginal, substantive or structural (Oakley, 1989). The first one implies little influence on the development process; the second involves controlled influence; while with the third one, people play an active and direct role in the project development (Oakley, 1989).

In health, community participation builds the interaction of people (Rifkin, 1990) and is the basis of successful health promotion, and a central and defining principle of health promotion, the *Health for All* strategy and the *Ottawa Charter* (WHO, 2003). Health promotion programmes are more likely to succeed

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when there is effective community participation (Butterfoss et al., 1996). However, in recent years, the WHO has argued for the replacement of the term 'community participation' with 'community involvement' because the latter has the implication of a deeper and more personal attachment and association of community members (Oakley, 1989). Authors generally agree that both community participation and involvement are reflections and markers of community engagement (Tindana et al., 2007; Oakley, 1989) and in reality, these terms are often used interchangeably. .

3.6. Models, Approaches and Policies for Engaging Communities in Health Promotion

There are many community engagement models in public health and health promotion (Patel et al., 2002) as many approaches to engaging communities have been developed over the years (Tindana et al., 2007). Some examples of underlying guiding principles to community engagement include:

- Conceptual frameworks for participatory action research used by the US Centers for Disease Control and Prevention (Principles of Community Engagement) (CDC, 1997);
- A guide to principles and practice effective engagement by the Effective Intervention Unit of Scotland (EIU, 2002);
- Guidelines for Health Research Involving Aboriginal People (CIHR, 2007) by the Canadian Institute of Health Research; and
- A model of engagement for socially excluded groups such as Black and minority ethnic groups by the Centre for Ethnicity and Health Community Engagement ((Fountain et al, 2007) at the University of Central Lancashire, UK.

Models frequently referred to in literature include consultation or public participation model; the asset-based or social economy model; the community democracy model; and the community organising model (Hashagen, 2002). The models based on an assessment of community needs and which engage communities to work as equals with agencies, showed to have contributed to increased community capacity, facilitation, support, resources and training; these models showed to be more sustainable leading to more empowered and

cohesive communities with better access to services and improved overall experiences and health outcomes (figure 3.4) (Fountain et al., 2007; Hashagen, 2002).

Figure 3.4 – Community Engagement Model.

The most researched, published and practiced approaches of community engagement (Tindana et al., 2007) include community organisation (Alinsky, 1971), community development (Freire, 1970), and participatory action research (Lewin, 1946). The World Café model has also been increasingly used in recent years as a way of engaging communities in conversations about their health and wellbeing (Brown & Isaac, 2005).

Community organisation is a process through which communities are provided with tools and supported to increase their capacity to identify common problems or goals, mobilise resources and develop and implement strategies for reaching their goals, which they have collectively set (Laverack, 2007; Minkler & Wallerstein, 2002; Mattessich & Roy, 1997; Minkler, 1997). It is a natural process of recognising priority issues and setting goals (McKenzie et al, 2005; Minkler, 1999; Braithwaite, 1994). It is based on the assumptions that communities can be supported to develop the capacity to make change happen by participating in decision-making (Ross, 1967). Rothman (2001) identifies three models of community organisation as a) locality development; b) social planning; and c) social action or community action (Rothman, 2001). Examples of models of community action for health promotion are: the People Centred Health Promotion (PCHP) model (Raeburn & Rootman, 1998); the

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PRECEDE-PROCEED model (Green & Kreuter, 1992); and the EMPOWER model (Gold et al., 1997).

Critiques of community organisation argue that it is largely problem-based, focusing on pre-defined problems; and mostly dependent on external technical expertise (Laverack, 2007; Minkler, 1999; Labonte, 1998).

Community development on the other hand, requires that the community define their own problems and needs, and work towards solving them with professional support and assistance and associated distribution of economic, infrastructural and political opportunities (Laverack, 2007; Minkler, 1999; Labonte, 1998). The approach involves raising community's awareness and critical consciousness of the role of political action in tackling inequalities through a democratic process of deliberation (Jones & Sidell, 1997; Freire, 1993; Cawley, 1984; Darby & Morris, 1975). It is therefore a way of promoting active civil society by prioritising the decisions and actions of people in the development of social policy; and it acknowledges the community as an asset with abundant resources to meet its needs. It is a community-initiated process of social change designed to create conditions of economic and social progress for the whole community with its active participation (Christenson & Robinson, 1989; United Nations, 1955).

A distinct feature of the community development approach is an appreciative enquiry approach to the skills and resources present in the community which can sometimes be referred to as an 'asset map'. Such approach offsets the needs by focusing on resources which include local institutions and the individual skills of people living in the community (Duncan, 2002; Mathie & Cunningham, 2002).

Community development recognises the close relationship between health and the social and material context within which people live, and a number of authors addressed this relationship through research and practice-based work (Slack, 2007; Marks et al., 2005; Bradshaw, 2003). Some examples include studies of the role of social networks and support among single mothers (Ward & Turner, 2007); the social inequalities affecting less-educated workers (Davis & Bosley, 2007); the home park residents' research (MacTavish, 2007); and the

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strategies and lessons for reducing persistent poverty (Richardson & London, 2007).

Community development aims to combat social exclusion and marginalisation by increasing participation and supporting people to acquire skills and social capital (Davies & Macdowall, 2006; Henderson et al, 2004). It involves relationship building within and outside the community; and has had a long history of tackling inequalities, removing the barriers to participation, and building active and sustainable communities (Davies & Macdowall, 2006).

Historically, community development has its roots in the establishment of the Country Life Commission by President Theodore Roosevelt in the US in 1908; and activities at the time were focused on improving life for rural Americans by creating local organisations to enable deprived communities to develop their own resources and become self-reliant (Christenson & Robinson, 1980). Following the success of this process, many urban areas translated the initiative to service their urban poor neighbourhoods in the 1940s (Christenson & Robinson, 1980). It did not substitute government's responsibility for providing social services for its citizens; rather it contributed to and influenced social policies to respond to their needs (International Association for Community Development, 2005). Examples of community development in the UK are the People Centred Health Promotion Programme and the Healthy Living Centres (Marks et al, 2005; Raeburn & Rootman, 1998).

Some of the key criticisms of community development include being time and resource-intensive; it requires mobilisation of a huge amount of human and material resources to support the community in defining its own health needs, deciding how these can be tackled, and taking appropriate action (Daly et al, 2002). There are also challenges in evaluating community development and mitigating potential conflicts that may arise as a result of setting priorities (Daly et al, 2002). Another critique is that self-appointed leaders, organisations or representatives may emerge, who claim to speak for all members of the community but who, in reality only represent the dominant group or interest in the community (Marks et al. 2005). However, community development still enjoys a huge amount of support because it starts with and focuses on the

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community's priorities and health concerns; and the skills acquired during the process can lead to sustainable improvements in health (Daly et al, 2002).

Participatory action research (PAR) is a valuable applied research tool for both science and practice because it involves the participation of communities in the decision-making processes which affect them, while accumulating knowledge and learning (NICE, 2008; Brydon-Miller, 2005; Whyte, 1991). During PAR, research and community activities happen concurrently (Walton and Gaffney, 1991). PAR was first used in 1946 by Kurt Lewin; and aims to generate practical solutions which lead to social change through participation of the community and a working partnership with researchers (Brydon-Miller, 2005; Pope & Mays, 2000; Carr & Kemmis, 1986; Reason & Rowan, 1981). The process achieves an increased understanding and knowledge through research, and a desired change in the community through social action (Dick, 1997).

The community-based participatory approach in public health research and practice has provided a way to shift the decision-making power away from experts to the experiential knowledge of the average resident (Leung et al, 2004). The approach has been successfully used in several programmes including the United States' Racial and Ethnic Approaches to Community Health Across the U.S. (REACH U.S.) programme which aimed to eliminate racial and ethnic differences in health status by addressing several health problems like diabetes, asthma, breast and cervical cancers, cardiovascular disease, hepatitis B and infant mortality in minority ethnic communities (Centre for Disease Control and Prevention, 2010). In the UK, the NHS Research and Development Strategy and the Cochrane Collaboration both emphasise the need for research and development activities in national initiatives (Pope & Mays, 2000).

The World Café is a community engagement tool which arouses collective intelligence around an issue and combines innovative approaches with the simple idea of having conversations about the issues that are important to the community (Brown & Isaac, 2001). It started as a means of having strategic dialogues about global issues and was first hosted by Juanita Brown and David Isaacs in the USA over 10 years ago (World Cafe Community, 2008). The World

Café idea is based on the assumptions that conversations are natural processes which can be harnessed to focus on priority issues, and that people have the knowledge and creativity within them which can be accessed and used to provide context for community issues (World Café Community, 2008). Though the process is informal, there are café guidelines which help foster dialogue and active participation by emphasizing etiquette which allows everyone contribute equally (World Café Community, 2008). There are also seven guiding principles which help the process achieve its goals (Brown & Isaacs, 2005). These principles are: a) explain clearly the reason for the meeting and what will be discussed; b) make the venue safe, warm and comfortable for the participants; c) explore the question(s) in a logical progression; d) encourage participants to contribute their ideas and perspectives; e) connect the different ideas and perspectives; f) pay attention to emerging patterns, themes and insights; and g) harvest and share collective discoveries with the whole group.

The café is set up to create an ambience of informality and warmth; music and refreshments should be provided, and tables may be decorated with flowers or candles and set up to seat four to six people. Conversations take place at each table on the same issue, and then participants move around to other tables to continue the conversations, taking with them the ideas from their previous table. Participants may also write down their ideas on the tables. The conversations link and build on each other as people move between groups, cross-pollinate ideas, and discover new insights into the questions or issues that are important (World Café Community, 2008).

This process of 'cross-pollination' of ideas within the room is an interesting and important one in the world café approach because it develops new connections and themes, and increases and shares new knowledge (Brown & Isaac, 2005). Figure 3.8 shows a graphic illustration of how ideas are cross-pollinated within a café meeting. It is at the point that patterns are identified and collective knowledge grows that opportunities for action emerge (Brown & Isaac, 2005). A graphic recorder/ artist can make collective knowledge visible by providing graphic representations of emerging ideas and themes. This helps to harvest, share and document ideas and themes that emerge and serves to complement written notes (World Café, 2008).

The most important factors in a cafe are having the right question(s) for discussion and having a good facilitator that can carry the process through (World Café, 2008). The question must be one that matters to the participants, and should be simple and clear, but thought-provoking and able to open up new possibilities and surface unconscious assumptions (World Café, 2008; Brown & Isaac, 2001).

Figure 3.5 – World Café cross-pollination of ideas. *Source: World Cafe*
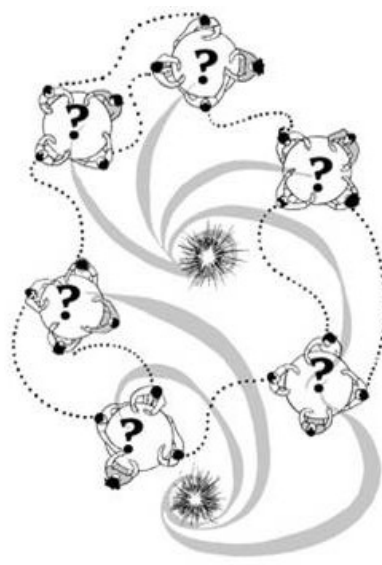
3.7. Policy Framework for Community Engagement in the UK

The UK national government recognises that community involvement, particularly the involvement of socially and economically disadvantaged groups, is important to the success of national strategies to promote health and wellbeing and to reduce health inequalities (Department for Communities and Local Government (DCLG), 2006; Electoral Commission, 2005; Department of Health, 2004) because involving them could help make policy initiatives more sustainable (Gilles, 1998; Rifkins et al, 2000; Wallerstein, 2006). The government has integrated health considerations into its social policies and the work of its other sectors through guidance policies on community engagement and tackling social determinants of health. Guidance documents, legislative acts, strategic and statutory instruments, and toolkits have been used to place community engagement on the agenda of government and non-government agencies in the UK in the last 10 years.

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In 2004, the Health Development Agency (HDA) published the '*Developing healthier communities: An introductory course for people using community development approaches to improve health and tackle health inequalities'* (Henderson, Summer & Raj, 2004) to provide a learning toolkit for community workers to prepare and update them on the skills, experience and resources needed to deliver effective community engagement. The *Local Government and Public Involvement in Health Act 2007 (Chapter 28)* came into effect in 2007 and the Local Involvement Networks (LINks) was created under this act to replace the Patients' Forums. The LINks was created to promote and support the involvement of local people in the processes of commissioning, delivery and evaluation of local health and social care services. The UK government policy *Creating Strong, Safe and Prosperous Communities – Duty to Involve* (2008) is underpinned by the fact that community engagement improves the health of communities, and the need for participation of local residents in the processes of commissioning and delivery of services to increase government and organisational accountability to taxpayers and service users (Campbell, 2009; DCLG, 2008).

In the same year, the DCLG published its legislation and policy document for local authorities and stakeholder partners - *Creating Strong, Safe and Prosperous Communities: Statutory Guidance,* which covered the duty to involve and responsibilities regarding the Local Area Agreements (LAA), Local Strategic Partnerships (LSP) and the Local Government and Public Involvement in Health Act 2007. It provided a comprehensive guide to engaging residents and providing accessible, innovative and effective services (DCLG, 2008). The document which contained the strategic action plans for delivering this 2008 document – *Strong and prosperous communities –The Local Government White Paper: Final Implementation plan -* was published in 2009. In addition, a good-practice and guidance document -*Planning Together: Updated practical guide for local strategic partnerships and planners* (DCLG, 2009) was published; this guide replaced an earlier LSP document published in 2007.

Several opportunities for community engagement have been created in various sectors including school governing bodies; Foundation Hospitals, Primary Care Trusts, Public and Patient Involvement Forums, Healthy Living Centres;

Tenant Management Organisations; Local Strategic Partnerships, Community Empowerment Networks, Community Chest, New Deal for Communities Board, Civic Pioneers, Local Area Agreements; Youth Offender Panel, and Police Consultative Panels (DCLG, 2008). The NHS has developed several mechanisms for people to participate in decisions about the NHS and its policies, and these policies seek to ensure that local authorities, the NHS, and other statutory agencies consult and involve the local communities in decisions related to policy, service delivery and quality of life (Gold, 2005). The most typical NHS examples of such partnerships include Foundation Hospitals, Primary Care Trusts, Public and Patient Involvement Forums, and Healthy Living Centres (DCLG, 2008).

3.8. Research on Community Engagement

As this study views community engagement and subsequent empowerment as both a process and an outcome, two types of earlier research were particularly important here: research into the process of community engagement in health, and research on the impact of community engagement on communities and their health.

3.8.1. Research into the Process of Community Engagement

A number of studies looked at the factors which affect community engagement, what makes the process effective and successful, what encourages people to participate, and what may constitute barriers and challenges. For the purpose of this review, these factors were divided into three groups: characteristics of communities; organisational issues; and perception of community engagement and its benefits.

3.8.1.1. Characteristics of Communities

A number of studies looked at the socio-demographic characteristics of communities engaged and identified gender, age, socio-economic status, geography, marginalisation and social networks as factors influencing participation (Jordan et al., 1998).

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Thus, women were found to be just as involved in CEP as men, but they preferred informal ways of engagement (Lowndes, 2004), and their participation appeared to wield less influence (GEM Project, 2004). The GEM Project in Manchester, UK found that the motivations for, and barriers to participation for men and women differed. Men and women showed different experiences and use of their neighbourhoods; they demonstrated different aspirations and mobilised around different issues (GEM, 2004). Formal meetings proved to be intimidating for some local women (GEM Project, 2004). Women's traditional roles in relation to family and domestic work proved to be one of the main barriers they faced when it came to participating in community activities and decision-making (Lowndes, 2004). Women are also more affected by practical barriers such as timing of meetings, transport and venue than men are; they are more likely to experience language barriers and the lack of confidence or skills to negotiate particularly in the male-dominated talks (GEM Project, 2004). Factors that increased female participation were provision of childcare and transport, women-only sessions, safe locations, convenient timing of meetings, and a combination of formal and informal approaches (GEM Project, 2004). There is also evidence that men's participation may be unfavourably affected by the attitude of service delivery staff who may stereotypically assume that certain engagement activities such as those that involve roles as parents were for women (Lloyd et al., 2005)

Age has also been found to be a factor in community engagement. Coulthard et al (2002) for example, found that young people participated less in civic and other local organisations than other age groups (Coulthard et al., 2002). The majority of young people of both sexes involved in the GEM project in Manchester said they did not feel welcome at meetings and community processes (GEM Project, 2004). Glaser (2001) explained the influence of age through an inverted U-shape relationship between age and social capital, with older people having more social engagement due to social relationships they have accumulated throughout their lifespan. Lowndes et al (2005) explained the higher levels of engagement of older people through the links between age and spare time they had.

Socio-economic status was found to impact participation (Coulthard et al., 2002). The Home Office Citizenship Survey (2004) in the UK reported that people in affluent areas were more likely to engage in various forms of civic

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participation than those in disadvantaged areas (Home Office, 2004). Some argue that this may be because the affluent groups have greater resources and skills to support advanced levels of participation around the issues which are important to them or their family and friends (Birchall & Simmons, 2004). Chanan (2003) argued that participation of poorer community groups is affected by lack of money, resources and skills, problems with childcare, poor access to transport, unsafe environment, and stress (Chanan, 2003). Some authors suggested that civic engagement among disadvantaged communities is usually less formal as poorer communities shy away from involvement in committee-like organisations and structures due to lack of education and self-confidence (Taylor, 2003).

Geographic location of certain communities can make it difficult for the members to come together. Thus, studies of community engagement geographies found that participation can be affected in some rural areas where there are barriers of greater distances, disbursed populations, smaller settlements, extended travel time, and transport and communication difficulties (NCVO, 2003). However, Debertin and Goetz (1997) found that geographic isolation on the contrary, provided a stimulus for the development of social capital and increased participation (Debertin & Goetz, 1997).

Marginalisation can affect participation. Thus, disabled people tend to be more excluded due to not only their disabilities but also because they are more likely to be in a lower socio-economic group and less likely to be employed than their able-bodied counterparts (Barnes & Mercer, 2003). However, marginalisation can be a stimulus to participation as minority groups can mobilise around certain issues which are specific to them (Barnes & Mercer, 2003). Some studies also suggest high levels of commitments to participation in such groups, as these commitments derive from personal experiences of difference, exclusion or disadvantage, as well as from an awareness of being a representative of 'a people' or an area or to a specific problem (Barnes et al, 2004).

Finally, a number of studies found that existing patterns of social networks influence participation. Thus, Lowndes et al (2005) found that people involved in existing associations were more likely to participate in community activities

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(Lowndes et al, 2005). Stoker (2005) examined psychological aspects of social networking and found that those who had a sense of togetherness or shared commitment were more likely to engage in their communities (Stoker, 2005). Lowndes (2004) found this to be particularly true in women when she studied the differences in patterns of social capital and involvement in local politics in men and women in Britain (Lowndes, 2004). Birchall and Simmons (2002) examined the networks of people, and found that around 80% of them engaged into community activities were recruited by people they already knew (Birchall & Simmons, 2002). Similar links between community participation and personal connections were found in other studies (Pattie et al, 2003; Verba et al, 1993).

3.8.1.2 Organisation and Delivery Factors

A number of authors examined organisational aspects of community engagement processes and found that many factors affecting community participation lie in the way community activities are communicated and delivered. Some authors argued that community engagement can be time-consuming for community members. Therefore, although many people theoretically support community engagement, in practice, very few are ready to put in the time and resources required to develop and sustain it (Butin, 2007). Sheri Arnstein (1967) likened participation to eating spinach where everyone agrees that it is good practice but no one is willing to do it readily.

One of the key factors affecting community participation identified in academic literature is access to information. Romanow (2002) reported that participation and consensus improved when people were provided with information during the deliberations on the *'Future of Healthcare in Canada'* (Romanow, 2002). Access to information was also linked to socio-economic status, with three quarters of people living in less deprived areas reporting that they felt informed about local issues compared to less than half of people living in more deprived areas reporting the same (Coulthard et al., 2002).

Barnes et al (2004) did a study of public participation in Birmingham and Liverpool, and found that the way in which the target group for engagement is defined and recruited greatly impacted the level of participation (Barnes et al, 2004).

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Some studies found that lack of public spaces where people could engage in public dialogue affected community engagement; while some studies looked at the logistics and design of the community engagement processes such as the timing of the events and the location of the meetings (Scutchfield et al., 2006; Duncan, 2002) and how they can exclude individuals like older people, parents of young children and disabled people (Barnes et al., 2003). A number of studies found that inadequate resources allocated to community events can affect participation. Some studies also identified unrealistic timescales as the problem for engagement (Korczak, 2006; Lowndes & Wilson, 2001).

The organisational culture may also act as a barrier to participation especially where there is deep-seated power relations which can be further perpetuated by the formal language, terminologies and procedures used; and members of the community may find these confusing and difficult to comprehend (Taylor, 2003). Barnes et al (2003) argued that the members of the community who are not experienced in formal ways such as bureaucratic communications can be alienated from the engagement process (Barnes et al., 2003).

3.8.1.3. Perception of Community Engagement and its Benefits

The last group of factors examined here is rather complex and refers to the community members' perceptions of and attitude towards engagement. A key barrier to engagement is the experience and perception of the community that there will not be tangible positive outcome following their participation; and that the service provision, policy and attitudes of decision-makers will remain the same (Chau, 2007; Lowndes & Wilson, 2001). This perception may result from historical experience and can affect the level of trust and relationship between the community and service providers (Taylor, 2006; Goodlad, 2005; Russell, 2005; Sullivan & Howard, 2005; Barnes et al., 2004; Chouhan & Lusane, 2004; Cole et al., 2004). Lawless (2004) found that residents from disadvantaged areas who had previous experiences of regeneration were extremely difficult to engage in similar programs (Lawless, 2004). A number of authors examined community apathy, scepticism and consultation fatigue, and explained these by disempowerment and poverty (Korczak, 2006; Lowndes & Wilson, 2001). Community participation may also be constrained by lack of consensus within the community, or conflicts, divisions and tensions (Korczak,

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2006; Lowndes & Wilson, 2001), particularly between the community and the professionals (Taylor, 2003).

3.8.1.4. Increasing Community Participation

A number of empirical studies looked at specific factors or interventions to encourage community participation. The literature identifies three groups of incentives: remunerative, moral and coercive. Remunerative incentives are material reward for participation; moral incentives include feelings that participation is the right thing to do; and coercive incentives apply when non-participation may result in negative consequences (Sullivan & Sheffrin, 2003).

A number of authors argued that perception of community participation by communities is often determined by the perception of ownership (McBride & Korczack, 2007). Several studies showed that an effective and sustainable community engagement is achieved through a substantial commitment of time and energy to build the necessary trust among different engagement stakeholders (Taylor, 2003; Arnstein, 1969). Coxon (2007), Hashagen (2002), and Church et al, (2002) showed that an appropriate entry point into the community was through an existing trusted community-based organisation with its roots in the community; and through trusted community leaders who are able to bring people together, facilitate engagement, and promote action (Coxon, 2007; Hashagen, 2002; Church et al, 2002).

Studies also looked at the role of a comprehensive understanding of the community by those involved in community engagement and showed that key pre-requisites of a community engagement success are: knowing the community, understanding its socio-economic and cultural make-up and being honest and open with the community (Coxon, 2007; Hashagen, 2002; Church et al, 2002). It is also important to understand and acknowledge the similarities and differences between and within the communities (Hashagen, 2002).

NICE did a review and synthesis of available evidence on community engagement in the UK and produced a guidance document - *Community engagement to improve health - NICE Public Health Guidance 9* (NICE, 2008), and an accompanying *Quick Reference Guide*. The document made recommendations on aspects of community engagement that can support its

effective implementation. These included: a) policy development, long-term investment, organisational and cultural change, levels of engagement and power, mutual respect and trust; b) infrastructure (training and resources, partnership working, area-based initiative); c) using community members as the agents of change, community workshops; d) evaluation; f) implementation; and g) recommendations for future research to fill the identified knowledge gap.

Stuart Hashagen and Alan Barr (2002) at the Scottish Community Development Centre developed a tool, Achieving Better Community Development (ABCD) as a framework for planning, evaluating and learning from community development initiatives. It encourages community development workers to document their aims and objectives, methods, and the lessons learnt from their experiences, including what they would do differently (Barr & Hashagen, 2002). The tool assesses the community development part of public projects (Davies & Macdowall, 2006). It involves the participation of every stakeholder involved in the process including the funders, policy makers, volunteers, community voluntary organisations, community development workers and the members of the community (Barr & Hashagen, 2002; New Economics Foundation (NEF), 2002). It is a flexible, broad and non-prescriptive framework and therefore does not tell the organisations or people involved how to go about their work; rather, it encourages that the evaluation process be based on the organisational and individual motivation, aims and objectives which may be reflected in the indicators and outcomes such as sustainability, empowerment and improved quality of the community (Scottish Community Development Centre (SCDC), 2002; NEF, 2002). However, due to its flexibility, it may have limited use for organisations that prefer to work with standardised structured evaluative tools (NEF, 2002). Other limitations in the use of the tool are that it does not involve an external evaluation and it may not be suitable for certain processes because it does not have financial and economic evaluation strategies; and may potentially exclude some individuals or organisations who are not dominant in the community (SCDC, 2002; NEF, 2002).

3.8.2. Impact of Community Engagement

There is some empirical evidence which point to the fact that the impact of community engagement may vary according to the characteristics of the

target population (Davidson et al., 1994; Morris et al., 1994; Arbeit et al., 1991). However, this has not been wholly substantiated and it is not fully understood how the effectiveness of community engagement should be conceptualised or measured in a universally accepted way (Tindana et al., 2007). It is generally accepted that the most important outcome of an effective CEP is community empowerment where power structures shift influences and responsibilities are shifted from centralised agencies to the hands of the (DCLG, 2008). This essential outcome can be manifested in multiple ways. For example, Attree & French (2007) found that empowerment can be manifested as increased social capital, trust in government organisations, and health enhancing attitudes and behaviours (Attree & French, 2007). Putnam (2000) and Williams (2003) found that increased social capital and subsequent social cohesion in communities led to increased interactions between people, social networks, trust, coordination and cooperation, and this impacted patterns of health (Williams, 2003; Putnam, 2000). These changes result in long-term benefits to the community (Hancock et al., 2001; Fisher et al., 1998; Hingson et al., 1996; Kumpusalo et al., 1996; Hunt et al., 1993).

Other studies reported building consensus within the community, greater community trust, increasing understanding and trust in government processes, and ability to manage and minimise the fear and uncertainty that accompany change (McBride & Korczack, 2007) as essential outcomes of community engagement. Furthermore, community participation can lead to reforms in the community and can open up new avenues and possibilities that were not previously considered or which were thought to be against what the public wanted (Maxwell et al, 2003), such as the consensus of participants to an increase in taxes earmarked and spent on healthcare during deliberations on the future of healthcare in Canada (Romanow, 2002).

There is a distinct identifiable link between CEP which produces empowerment of the individuals and communities, and positive health outcomes (Butterfoss et al., 1996) and a number of empirical studies looked at the impact of community engagement on health-related outcomes, particularly in socially excluded groups as a way to create more equity by increasing people's confidence in their own abilities and equipping them to influence the decisions that affect their health (Wallerstein, 2006).

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Over the years, community partnerships and engagement in the design of health promotion interventions have effectively addressed community health issues such as high prevalence of teenage pregnancy (Vincent et al., 1987); cardiovascular diseases (Samuels, 1990); increasing uptake of healthy eating (Kumpusalo et al., 1996; Hunt et al., 1993); substance misuse (Hawkins & Catalano, 1992); mental ill-health (Fawcett et al., 1994); childhood infectious diseases and low uptake of immunization (US Department of Health and Human Services, 1994); violence (Wilson-Brewer et al., 1991); and injury prevention (Davidson et al., 1994; Morris et al.,1994). Community-based interventions involving community engagement showed to be particularly effective in producing short, mid and long-term positive changes in the level of physical activity (Hillsdon et al, 2003; Pargee et al., 1999; Williams & Olano, 1999); but no short-term benefits were reported from interventions targeting healthy eating and smoking (Melhuish et al., 2005; ODPM, 2005; Rhodes et al., 2005).

Community engagement has also been found to have a positive impact on the way residents' perceive their neighbourhoods and crime in their neighbourhoods (DCLG, 2006; Pawson et al., 2005; Rhodes et al., 2005; Carr-Hill, 2003); the way information flows within the community and between the community and service delivery organisations (Taylor et al., 2005; Craig et al., 2002); and on social cohesion (Taylor et al., 2005; Winters & Patel, 2003; Craig et al., 2002). It has also been found to improve the level of participation of minority ethnic community members and the recruitment of new volunteers (Goodlad et al., 2003; Cairncross et al., 2002; Tunstall, 2001).

Community participation has been associated with improved health outcomes in the community as a result of improved structural and socio-economic environments, control over health-damaging activities in the community such as drug-dealing and alcohol abuse (DCLG, 2006; Rhodes et al., 2005; Carr-Hill, 2003; Wallerstein, 1993; Eng, 1989) and through strategies which create equity, build capacity and redress power inequity (Wallerstein, 2006). For example, Conway (2002) described community actions against alcohol abuse and related injuries in Piha, New Zealand, where a ban on public drinking driven by local communities reduced the levels of injuries and crime and helped to achieve an improved sense of wellbeing among the residents which in turn led

to sustained changes in social and organisational environment (Conway, 2002).

However, some authors have argued that these benefits may benefit communities that are less disadvantaged than those that are more disadvantaged; and target groups such as older residents and minority groups tend to benefit more (Carr-Hill, 2003; Melhuish et al., 2005).

Some authors tried to explain the mechanisms through which community participation impacts health. Brehm & Rahn (1997) argued that participation strengthens and improves social networks and support in such a way that individuals in a community have a better chance of achieving health goals when they participate and form networks with people who are affected in the same way as they are or who have similar circumstances (Brehm & Rahn, 1997). For example, in the North Karelia project in Finland in the 1970s, people held one another accountable for living healthy and even checked each other's fridges to make sure they used butter instead of margarine (Pushka, 1995). As a result, lifestyle habits such as smoking and dietary habits have changed, mortality rates from cardiac diseases and cancers reduced, and life expectancy has increased in the area (Pushka, 1995).

Individual and collective skills and competencies acquired through opportunities provided by CEP is another way to improve the health of individuals and communities. Some examples of skills and competencies acquired are: knowledge and social support for smoking cessation, dieting, exercise classes; teambuilding, networking, planning and strategy development, marketing; improved literacy and education especially for women (Pokhrel & Sauerborn, 2004; Bratt et al, 2002).

Empirical evidence of the impact of community participation on the content and delivery of health interventions are limited (Swainston & Summerbell, 2008). However, there are tools used in the planning and management of public programmes that facilitate community involvement in the design of the programmes that may affect their health. The Health Impact Assessment (HIA) tool assesses the health impact of public projects, policies and programmes which may or may not have health as its central theme. The tool has the potential to inform and open up decision-making processes by ensuring that

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evidence of potential impacts is considered (Home Office Crime Reduction College, 2002; Taylor & Blair-Stevens, 2002). HIA provides a knowledge base for those who may want to run similar projects (Home Office Crime Reduction College, 2002). Similar assessment tools have been developed for specific aspects of health outcomes, for example, the Mental Wellbeing Impact Assessment (MWIA).

Chapter 4 – Well London Programme

4.1. Introduction

The Well London (WL) programme is a health promotion and community engagement programme delivered between 2007 and 2011 in the city of London. London is a multi-cultural city with its fair share of diseases and health risks associated with inequalities, some of which are geographically or area-based. The areas where these health inequalities abound are those characterised by a high proportion of unemployment, minority ethnic groups, ill-health, poor housing and living conditions (Wall et al, 2009) which result in multiple deprivation and marginalisation of the communities living there. The WL programme described here aimed to promote mental health and wellbeing, healthy diets and physical activities in a number of these deprived communities in London by helping to alleviate some of the barriers which prevent healthy lifestyles in the resident populations. Unhealthy diets, low physical activity and mental ill-health are among the key public health problems in the UK, accounting for ten, three and 19 per cent of DALYs respectively, and there are clear links between these health risks and deprivation (Allender et al, 2007; Sainsbury's Centre for Mental Health, 2006; Rayner & Scarborough, 2005).

Community engagement was a central part of the WL programme, and provided a setting and a framework for empirical work conducted in this study.

4.2. Overview of the Well London Programme

The WL programme is a health promotion programme which aimed to improve the health and wellbeing of 20 deprived communities in London by tackling three of the key determinants of health: diet, physical activity and mental wellbeing. The programme started in 2007 and was funded by a grant from the Big Lottery Fund. It is an initiative which was based on the philosophy and logic of working at a very local level in the most deprived communities; using community development and co-production approaches to design intervention and evaluation; and providing rigorous evaluation through learning

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and evidence to support mainstreaming and roll out of the programme. It aspired to facilitate community-led projects which were delivered in partnership with local providers through the use of innovative approaches which included the use of arts and culture (Well London, 2007).

The delivery of projects by the programme had been designed to go through a multi-level of agencies to the wider target communities. Delivery process started with strategic governance by the London Health Commission, then the WL strategic alliance partners through to the local delivery organisations who delivered the projects to the communities. Other activities such as baseline surveys, assessments, action research, monitoring and evaluation, learning networks and training, and practice development were delivered concurrently (Figure 3.2).

Figure 4.1 – Multi-level Delivery of the Well London programme. *Source: London Health Commission, GLA (2007)*
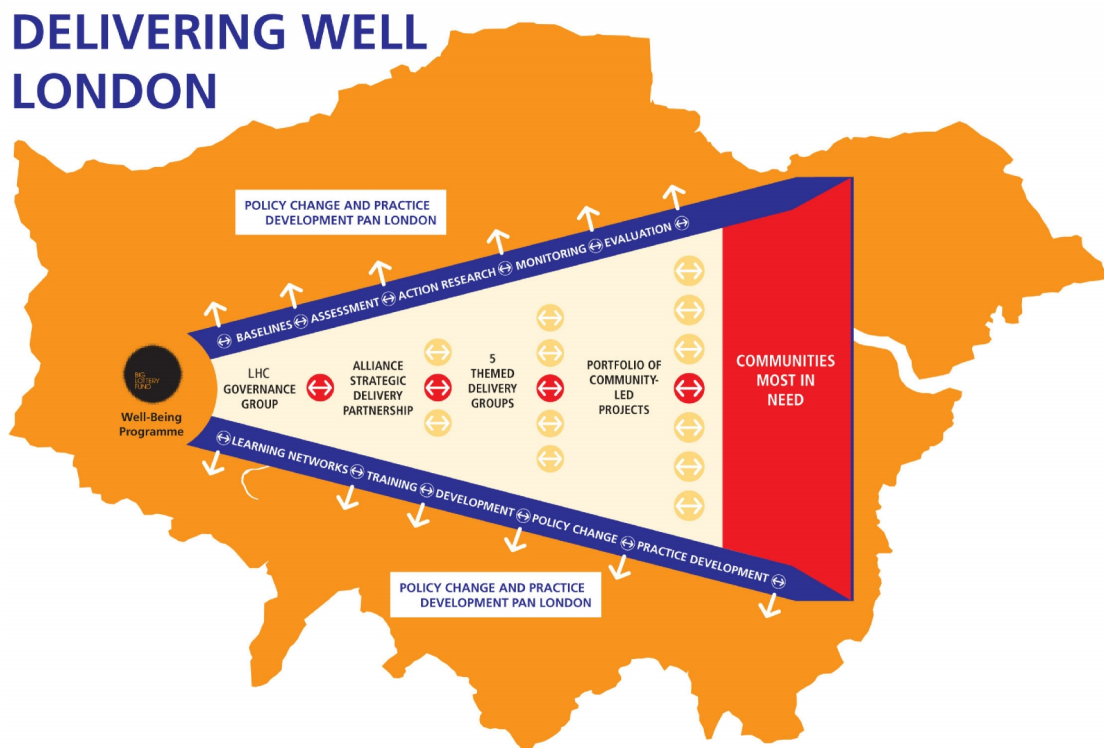
The programme was delivered by a consortium of seven organisations (the WL alliance partners) in collaboration with the local delivery organisations in each area. Each partner was responsible for their respective thematic activity (healthy eating, mental health, physical activity, arts, and green spaces) and coordination of all activities in two to three LSOAs.

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The evaluation of the programme was designed as a cluster randomised controlled trial with 20 intervention and 20 control areas. Data for this evaluation was collected via (a) cross-sectional surveys of adults and adolescents before and after health promotion interventions; (b) a survey of structural and environmental characteristics pertinent to health in the intervention areas; and (c) a complementary qualitative longitudinal study of how the interventions affected the communities and individuals living in those communities (Wall et al, 2009).

The CEP took place in the first year and preceded project delivery; it was used as an approach to community needs assessment and co-development of interventions (WL, 2007). Although the process of design of intervention projects was identical in all communities, the content of project portfolios delivered varied according to the identified local needs. As a result, the types and numbers of projects delivered in each area varied; for instance, one community received one physical activity project, four arts and cultures projects, two healthy open spaces projects and one healthy eating project, whilst another community received three physical activities projects, one arts and culture project, two healthy spaces projects and two healthy eating projects. However, the number and types of projects available within the programme had already been identified as part of the original project design in the Big Lottery Fund grant proposal.

4.2.1. Selection of Communities for Well London

Each of the WL intervention communities corresponded to a Lower Super Output Area (LSOA). The LSOA was chosen as the unit for programme delivery because it allowed for identification of pockets of deprivation. The Super Output Area (SOA) is a unit of geography used in the UK for statistical analysis (ONS, 2007). An LSOA is an area usually equivalent to about a quarter of an electoral ward, containing between 1000 and 1500 people, living in 800 to 1000 residential addresses, and covering about five to six streets (ONS, 2007). It is the lowest level of the geographical hierarchy used by the Office for National Statistics (ONS); therefore, it is the smallest area for which a wide range of routine data is available. There are 34,378 LSOAs in England and Wales, 32,482 in England and 4765 LSOAs in London (ONS, 2007).

LSOAs are ranked according to their deprivation scores based on specific dimensions of deprivation called the Indices of Multiple Deprivation (IMD) (ONS, 2007). The IMD is a ranking number which is derived from a collection of data from a number of chosen indicators into a single score for each area or LSOA which allows each area to be ranked according to their level of deprivation. The LSOA ranked '1' by the IMD is the most deprived whilst that ranked the highest number is the least deprived. However, these ranks are not relative measures and therefore do not measure how much more or less deprived an LSOA is relative to another (ONS, 2007). The indices are used widely to analyze patterns of deprivation, identify areas that would benefit from special initiatives, and as a tool to determine eligibility for specific funding streams (DCLG, 2007). The indices available for the year 2007 update the information provided in the IMD 2004 (ONS, 2007). There are seven domains or dimensions of deprivation which are weighted to provide the IMD 2007 scores. These seven domains are made up of 37 different indicators and include: income; employment; health; education; barriers to housing and services; living environment; and crime (ONS, 2007).

The selection of the WL LSOA communities was rigorous and stringent, using the 2007 IMD scores to select 20 of London's 33 boroughs which had at least four LSOAs in the most deprived 11% in the city (WL, 2007). The four most deprived LSOAs in each of these boroughs were then selected; maps and indicators were prepared for each of the four in the selected 20 boroughs. Following this, the local authorities and Primary Care Trusts in the boroughs were asked to choose two non-abutting LSOAs from the four presented in each borough. The two LSOAs selected in each borough were then randomly allocated to the intervention and control groups. This resulted in 20 intervention and 20 control areas. The boroughs where WL was delivered included Barking and Dagenham; Brent; Camden; Croydon; Ealing; Enfield; Greenwich; Hackney; Hammersmith and Fulham; Haringey; Hounslow; Islington; Kensington and Chelsea; Lambeth; Lewisham; Newham; Southwark; Tower Hamlets; Waltham Forest; and Westminster. The tables below show the selected boroughs, LSOA wards and information on LSOA population and IMD (tables 4.1 and 4.2).

When the WL boroughs were ranked against the average for England on indicators such as life expectancy at birth, health expectancy, wellbeing,

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readiness for school, income status, and percentage of young people not in education, employment or training, all the boroughs did poorly on most indicators; and two of the WL boroughs (Islington; and Barking and Dagenham) were considerably worse for all of the indicators (Baker et al., 2011).

Table 4.1 – Target LSOA, code, IMD, London IMD ranking and population

Borough	LSOA code	LSOA	IMD	Rank	Pop.
Barking and Dagenham	E01000061	Heath	53.75	148	1617
Brent	E01000529	Kensal Green	53.49	157	2216
Camden	E01000905	Haverstock	60.37	41	2032
Croydon	E01001013	Broad Green	48.95	309	1609
Ealing	E01001358	South Acton	48.99	307	1595
Enfield	E01001554	Upper Edmonton	54.44	130	1610
Greenwich	E01001703	Woolwich Common	58.22	64	1569
Hackney	E01001721	Brownswood	59.94	44	1468
Hammersmith and Fulham	E01001958	White City	47.87	343	1920
Haringey	E01002026	Noel Park	61.41	33	1670
Hounslow	E01002588	Cranford	43.1	585	1588
Islington	E01002720	Canonbury	63.87	16	1518
Kensington and Chelsea	E01002879	Notting Barns	48.61	318	1886
Lambeth	E01003092	Larkhall	51.78	207	1649
Lewisham	E01003192	Bellingham	52.07	199	1523
Newham	E01003503	Canning Town N.	62.25	28	1564
Southwark	E01004005	Nunhead	69.45	6	1600
Tower Hamlets	E01004252	Limehouse	70.9	4	1730
Waltham Forest	E01004407	Hoe Street	60.42	38	1456
Westminster	E01004722	Queens Park	63.46	20	2688

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Table 4.2 – WL Intervention and Control LSOAs *Source: Well London (2007)*

Borough	Intervention LSOA	Control LSOA
Barking & Dagenham	Beacontree Heath	Gascoigne
Brent	Kensal Green	Harlesden
Camden	Haverstock	St Pancras & Somers Town
Croydon	Broad Green	South Norwood
Ealing	South Acton	Southall Broadway
Enfield	Upper Edmonton	Edmonton Green
Greenwich	Woolwich Common	Woolwich Riverside
Hackney	Woodberry Down	Queensbridge
Hammersmith & Fulham	Wormholt and White City	Shepherd's Bush Green
Haringey	Noel Park	Northumberland Park
Hounslow	Cranford	Feltham West
Islington	Canonbury	Finsbury Park
Kensington & Chelsea	Notting Barns	Golborne
Lambeth	Larkhall	Coldharbour
Lewisham	Bellingham	Evelyn
Newham	Canning Town North	Canning Town South
Southwark	Cossall & Brimmington	Camberwell Green
Tower Hamlets	Limehouse	East India & Lansbury
Waltham Forest	Hoe Street	Cathall
Westminster	Queen's Park	Church Street

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The map below (map 4.1) highlights the boroughs and LSOAs selected for the WL programme and their geographic positions in relation to other London boroughs.

Map 4.1 - WL Boroughs and LSOAs *Source: Greater London Authority (2006)*
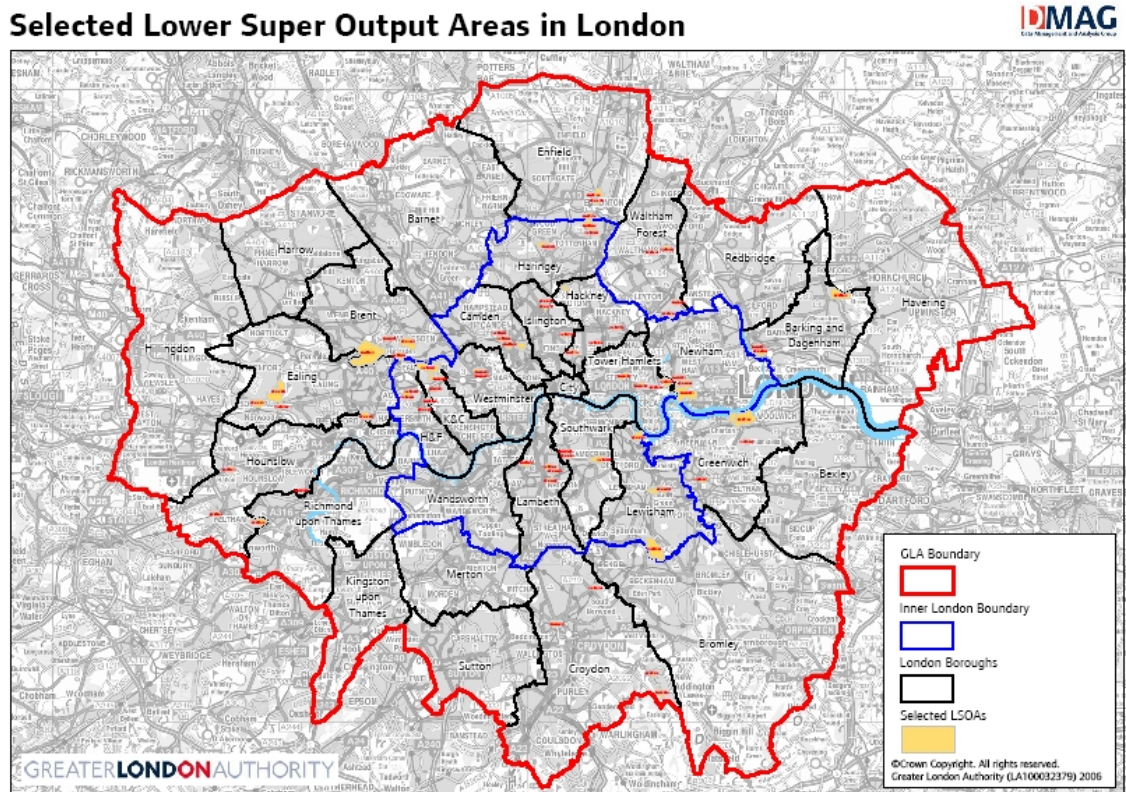
This study was conducted in some of the WL LSOAs and in the intervention areas only. The numbers of LSOAs included varied by data collection method, and are detailed in chapter five. The following four maps (Maps 4.2, 4.3, 4.4 and 4.5) show the LSOAs where all three data collection methods (surveys, participant observations and qualitative interviews) were used. The maps also give an illustration of the location and sizes of the LSOAs in relation to the surrounding built and ecological features.

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Map 4.2 - LSOA of Woodberry Down in Borough of Hackney *Source: GLA Well London website*
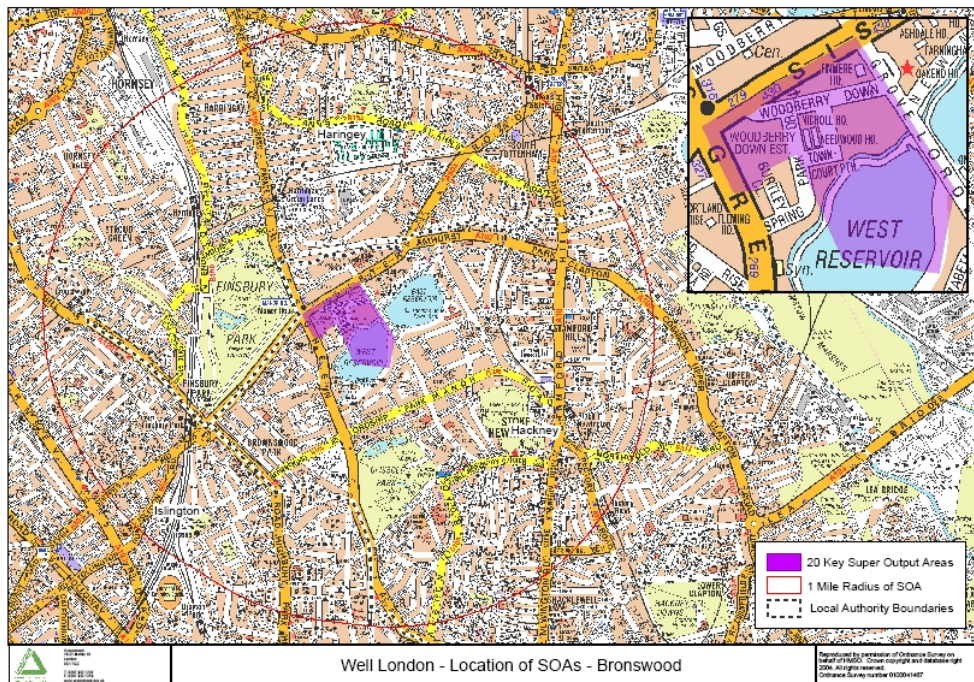
Map 4.3 - LSOA of Beacontree Heath in Borough of Barking and Dagenham *Source: GLA Well London website*

Map 4.3 - LSOA of Beacontree Heath in Borough of Barking and Dagenham *Source: GLA Well London website*

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions
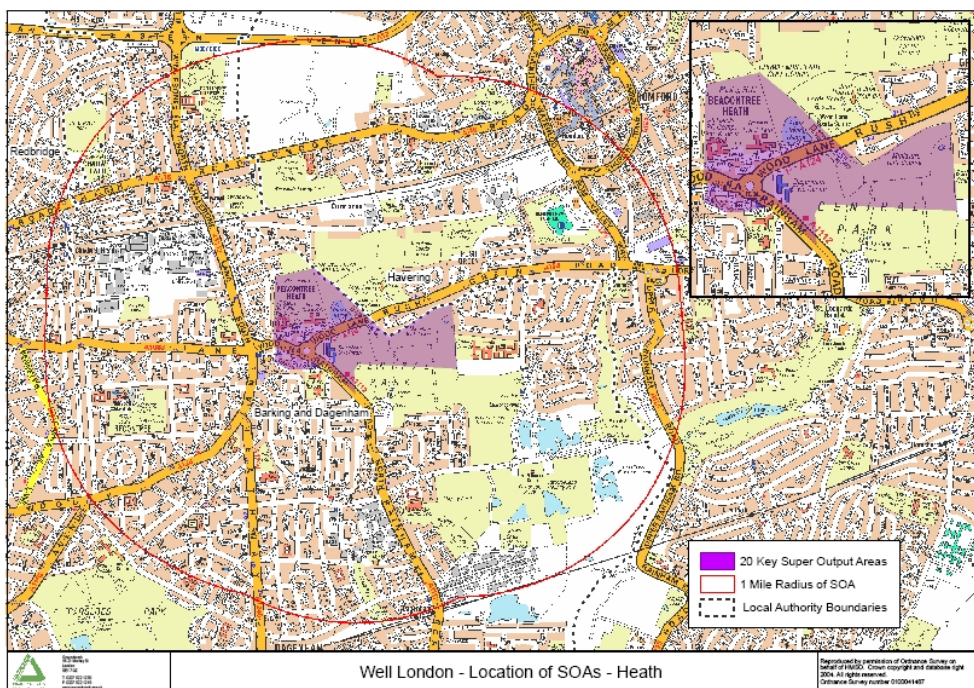
Map 4.4 - LSOA of South Acton in Borough of Ealing *Source: GLA Well London website*
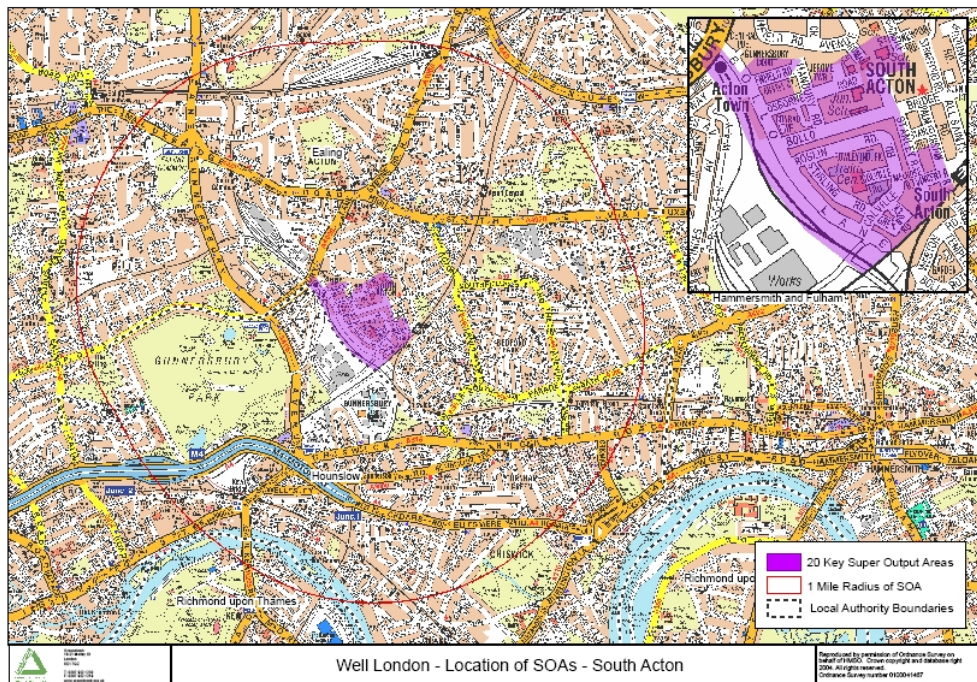
Map 4.5 - LSOA of Cossall & Brimmington Neighbourhood in Borough of Southwark
Source: GLA Well London website

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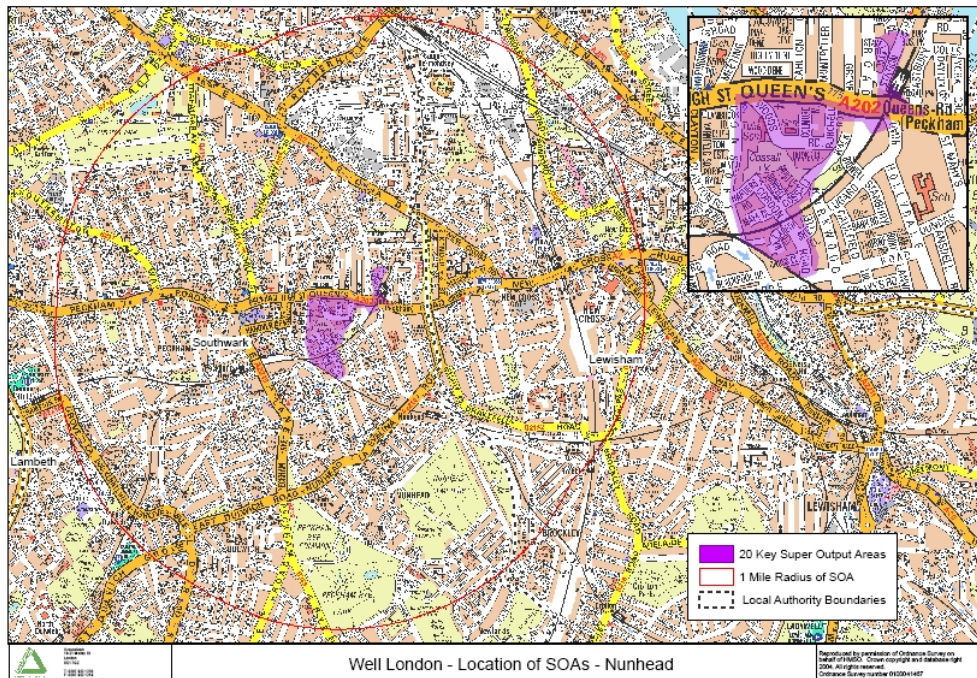
4.3. Well London Community Engagement Process (CEP)

The WL CEP represented the community needs assessment aspect of the programme. The CEP in each community involved a series of consecutive events, which started off with a community cafe (CC) followed by a community action workshop (CAW), and culminated in a project implementation meeting (PIM) in the community. There were two CC, one CAW and one PIM held in each target LSOA. The Consortium Portfolio Workshop (CPW) was not a community engagement event as it did not involve the participation of members of the community but it bridged two community events - the CAW and PIM. The CEP was intended to be an on-going process throughout the life of the programme to allow for feedback and evaluation of the projects. However, this study focuses on the evaluation of the CEP during the first (pre-intervention) stage of the programme only. The diagram below (Figure 4.2) shows the WL CEP and the involvement of the community in the stages leading to the development of a programme delivery plan for each target LSOA. The shaded boxes on the right side of the diagram show the events that had direct community residents' involvement while the two boxes on the left side show those parts of the process where there was no direct community residents' involvement.

Figure 4.2 – Well London Community Engagement Process. *Source: Well London (2008)*
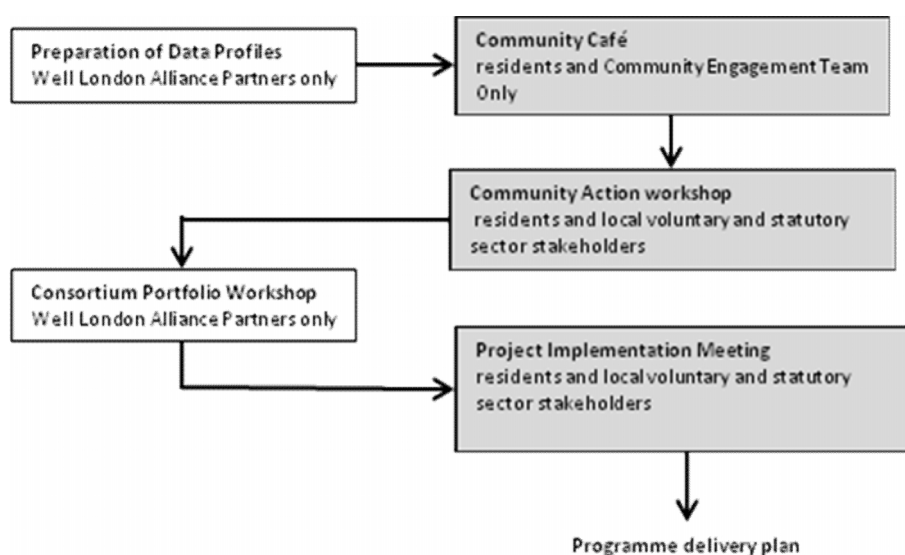
The objectives of the CEP were to ensure that the projects delivered to the communities were tailored to the specific needs of the target communities as

identified by the community residents themselves, making them the central focus at every stage of the programme. The CEP gave the community residents a documented voice in the design and implementation of health promotion interventions for them, so that their expressed needs could override the normative needs identified by professionals. Furthermore, the participation of the residents in the decision-making process stage was expected to encourage their participation in the interventions that they had helped to decide and plan.

Due to the large numbers of communities involved, the process was conducted in two phases. The first phase involved nine communities (Limehouse in Tower Hamlets; White City in Hammersmith and Fulham; Canonbury in Islington; Woolwich Common in Greenwich; Canning Town North in Newham; Kensal Green in Brent; Noel Park in Haringey; Broad Green in Croydon; Larkhall in Lambeth) and began in October 2007. The second phase of community engagement involved the remaining eleven communities (Beacontree Heath in Barking & Dagenham; Haverstock in Camden; South Acton in Ealing; Upper Edmonton in Enfield; Woodberry Down in Hackney; Cranford in Hounslow; Notting Barns in Kensington & Chelsea; Bellingham in Lewisham; Cossall & Brimmington in Southwark; Hoe Street in Waltham Forest; Queen's Park in Westminster) and commenced in May 2008.

4.3.1. Community Cafés

Following desk-based research into the health, wellbeing and available local services in the community which provided a data profile of the communities, and the selection of the local hosting organisations (co-hosts), community café events were organised and held. The cafés were delivered in the intervention areas only, and the role of the community engagement team was facilitation of residents' discussions and recording of the issues discussed by the residents. The WL alliance partner organisations were encouraged to send representatives to the community cafés, especially for those LSOAs where they were the coordinator (lead). This gave the partners an opportunity to be involved in the CEP and to meet face-to-face with the communities to whom they would be delivering the projects, and for them to acquaint themselves with the physical environments of the LSOAs.

The 'World Café' model was used to facilitate the community cafés. The residents were encouraged to discuss and identify key issues in the community that affected their health and wellbeing, in an informal and relaxed atmosphere. Two cafes per LSOA were conducted to achieve maximal attendance of the residents. These two cafes in each area were held on the same day with one in late morning or mid-day, and the other in the late afternoon or early evening. The timing of the cafes was to allow people to attend around their usual daily activities like taking children to school and going to work or school. Refreshments, crèche facilities, disabled support, and interpreters were available to facilitate attendance. The venues were located within or very close to the target LSOAs and were decorated to make the spaces more comfortable and inviting.

The first set of community cafes took place between 29th October and 16th November 2007 over a three-week period in the first nine LSOAs. The table below (Table 4.3) shows the attendance at the community cafes in the first phase.

Table 4.3 – Date and attendance of phase one community cafes

Borough	Date	1st café	2nd café	Total
Brent	12/11/07	15	6	21
Croydon	15/11/07	11	8	19
Greenwich	7/11/07	25	18	43
H&F	30/10/07	46	26	72
Haringey	13/11/07	22	9	31
Islington	6/11/07	22	-	22
Lambeth	16/11/07	24	16	40
Newham	8/11/07	35	6	41
Tower Hamlets	29/10/07	35	-	35
Total for Phase 1				324

In total 324 residents participated in these cafes; the attendance ranged from 19 in Croydon to 72 in Hammersmith and Fulham, with an average attendance of 36 residents in each area. Only one café was held each in Tower Hamlets and Islington because these were the pilot boroughs and cafes had already been held in these two areas as part of the piloting and bidding process.

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The second set of cafes took place between 8th May and 21st June 2008 over a six-week period, in the remaining 11 LSOAs. The longer time period for the second phase cafes was informed by the evaluation of the first phase. Spreading the events over a longer period helped to avoid the exhaustion and time-poverty which characterised the first phase. In total, 599 residents participated in this phase and the average number of attendants per LSOA was 55. The attendance varied from 33 in Lewisham to 90 in Westminster. The table below (Table 4.4) shows the attendance of the community cafes in phase two.

Table 4.4 – Date and attendance of phase two community cafes

Borough	Date	CC Attendance
Barking & Dagenham	21/06/08	48
Camden	08/05/08	57
Ealing	13/05/08	78
Enfield	29/05/08	44
Hackney	27/05/08	50
Hounslow	20/05/08	58
Kensington & Chelsea	15/05/08	45
Lewisham	16/05/08	33
Southwark	10/05/08	50
Waltham Forest	22/05/08	46
Westminster	30/05/08	90
	Total	599

All community cafés addressed the same question - "What do you understand as the health needs of your community?" This broad question was intended to encompass discussions around different aspects of health and wellbeing in the community, and residents were encouraged to be as specific or general as they wished in discussing the question. The picture below (picture 4.1) shows a cross-section of participants having table discussions at a café.

Picture 4.1 – Cross-sectional view of participants at a community cafe *Source: Well London (2007)*

One or two scribes were present at each table to take notes of the discussions. The notes of the plenary session were also taken by at least two designated note-takers. Participants could also write their thoughts on the paper table cloths which were later collected by the community engagement team at the end of the café.

In addition to the discussions, there were exhibition stands where the residents had opportunities to give more information about what they knew about their neighbourhood and the facilities available. This was done electronically and manually using maps and symbols. They were also able to highlight those areas that they felt unsafe in and those areas that they could relax or take a walk in. There were also blackboards where participants could write about what they understood or felt about the health needs of their communities, or express their health needs and propose ideas to meet these needs. The picture below (Picture 4.2) shows participants in the exhibition area of a café.

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Picture 4.2 – Community café participants engaging in participatory activities and exhibitions *Source: Well London (2007)*

The marketing of the café events was done through the local co-hosts organisations. One co-host per LSOA was selected; selection criteria were their proximity to the LSOA and their ability to engage with the target groups. The list of co-hosts involved is presented below in section 4.4.2. The marketing methods used were flexible and adapted to local conditions; they included leafleting in community languages, using influence-formers and word of mouth. In addition, the community engagement team and co-host organisations invited people walking by or near the venues on the day of the events. The picture below (Picture 4.3) shows a poster marketing the cafés in Barking & Dagenham. This is a typical poster used in most of the areas, but modified to take account of the different area names, dates and times of the cafes and venues. In some areas the posters were translated into other languages in the communities.

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Following the community cafes, the community engagement team transcribed and collated all the notes and analysed them thematically; they then prepared a CAW pack for each LSOA. This pack contained the collated discussion themes which emerged during the cafes, the community profiles which were derived from the desk-research exercise, and a description of the WL programme, potential projects and partners. About a week before the workshop, the pack for each borough was sent out to the residents who had participated in the cafes and who had provided contact details in those boroughs, and local stakeholders.

4.3.2. Community Action Workshops (CAW)

The workshops aimed to bring together local residents, local voluntary organisations and local statutory stakeholders, ideally in about equal numbers to achieve a dynamic and vibrant workshop, and to identify the ways of addressing health and wellbeing issues identified by the residents at the community cafés. CAWs used an appreciative enquiry approach which works on the assumption that every organisation and community works in the way which is best for them. The approach therefore aims to identify what works best for each community and what community experiences and aspirations are.

The workshops were more formal than the cafés. They began with a presentation of the information gathered from the cafes and the emerging themes of the expressed needs. There were opportunities for the participants to feedback on the presentation and to briefly discuss or add to the information already presented. This would usually set the tone for the appreciative enquiry session.

The workshop utilised various exercises within which the participants were encouraged to discover what works well in their community by talking about past experiences of successful projects; dream of what could be achieved, how the projects would look like; design and plan the delivery, including details such as who would be involved, which groups would be targeted, and who would be best placed to deliver the interventions. The workshop also gave the participants an opportunity to network with one another, ask questions, and hear residents' feedback.

The output of each workshop was a list of potential projects which could address the needs in that specific community given the infrastructure, resources, networks and relationships available locally. In addition, each area lead partner was expected to identify potential delivery partners and assess the factors that may facilitate or hinder the programme implementation.

Marketing methods used for the CAWs were similar to those used for the cafes although the CAWs were more reliant on formal structures and ways of communication.
The workshops were well attended by local voluntary and statutory sector organisations, while the attendance by residents varied, with some workshops recording very poor turnouts of local residents. One CAW took place in each LSOA; the first set took place between 20th November and 4th December 2007, in the first nine LSOAs; and the second set took place between 16th June and 2nd July 2008 in 11 LSOAs. The total number of people who attended the CAWs in phase one could not be calculated because figures for Tower Hamlets and Newham could not be obtained. The number of phase one CAW participants, excluding these two boroughs, was 116, ranging from nine in Lambeth to 25 in Haringey. The total number of participants in phase two was 304, ranging from

16 in Lewisham to 49 in Ealing. The following tables (Tables 4.5 and 4.6) show the attendance at the CAWs in phase one and two respectively.

Table 4.5 – Attendance at phase one CAWs

Borough	CAW Attendance
Tower Hamlets	unknown
H&F	16
Islington	11
Greenwich	20
Newham	unknown
Brent	19
Haringey	25
Croydon	16
Lambeth	9
Total	** unknown

Table 4.6 – Attendance at phase two CAWs

Borough	CAW Attendance
Barking & Dagenham	18
Camden	19
Ealing	49
Enfield	29
Hackney	30
Hounslow	28
Kensington & Chelsea	30
Lewisham	16
Southwark	37
Waltham Forest	16
Westminster	32
Total	304

At the end of the workshops, the participants were asked to come up with a set of priorities for their communities and a list of projects which would address these priorities. These lists of possible projects, and information on potential delivery organisations proposed by the lead partners were then taken to the CPW.

4.3.3. Consortium Portfolio Workshop (CPW)

The objectives of the CPW were information sharing and strategic planning and balancing for all partners; with the outcome of a draft portfolio and planned project distribution for each LSOA. The CPW was technically not a community

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engagement event because it was attended by only the WL alliance partners who met to fine-tune the outcomes of the CAWs and to decide what was deliverable in each community within the resources available. The lead partners for each LSOA compiled a list of the proposed projects and when, how and by whom they could be delivered.

The first CPW took place in December 2007; and 26 participants from the seven WL alliance partners attended the two-day workshop. Participants discussed some general programme matters and specific issues concerning individual communities and partners. These issues included clarification of roles within the programme; communication strategy; local advisory groups; co-hosts; co-production; and the implications for the 2012 London Olympics, particularly in the Olympic boroughs. The ten top themes which emerged from the phase one CEP were presented and discussed. These ten emerging themes were: 1) intergenerational and intercultural target audience; 2) youth engagement; 3) communication; 4) coordination; 5) leverage; 6) sustainability; 7) celebration; 8) flexibility; 9) skills acquisition; and 10) dog fouling.

The second phase CPW took place in September 2008. The agenda for this workshop was similar to the first CPW, except that by this time the programme was at a more advanced stage and there was more clarity on the roles and communication strategy within the programme. This second workshop discussed the issues of timely and coordinated delivery of the projects, and the ways of keeping the communities engaged.

The workshop produced a detailed portfolio of projects for each LSOA which was then presented back to the communities at the project implementation meetings.

4.3.4. Project Implementation Meetings (PIM)

The PIM was designed to bring together the local residents, local voluntary and statutory sector organisations, and the WL alliance partners; and to discuss the outcomes of the engagement events, and the implications for the programme delivery. The meetings were facilitated by the WL lead partners for each borough, and the details of the portfolio of projects designed for each area

were presented. Participants had opportunities to comment on and ask questions about the proposed portfolio, and feedback their thoughts about the projects planned.

The PIMs in the first and second phases were held in January and September 2008, respectively. The details of the contents of the project implementation documents (PIDs) are analysed later in chapter 10.

4.4. Well London Delivery Partners and Projects

4.4.1. Well London Alliance Partners

The WL alliance partners included seven organisations with different areas of expertise. The co-ordinating partner was the London Health Commission (LHC) whose specific experience lies in influencing policy and interventions in the Greater London Area. The other partner organisations included the Arts Council England (ACE); Groundwork London (GW); Central YMCA (C-YMCA); London Sustainability Exchange (LSX); South London and Maudsley NHS Foundation Trust (SLAM); and the University of East London (UEL). All the partners were centrally based in London and had been actively involved in the delivery of specialised services to communities and organisations throughout the capital and the UK. Appendix II provides a description of these partner organisations and the work they do.

In addition to the WL alliance partners, other organisations were involved in the delivery of the programme, and many of these organisations acted as co-hosts while some were involved in the intervention delivery. The co-hosts in phase one included *Elders Voice* in Brent; *Croydon Black and Minority Ethnic Forum* in Croydon; *Cripplegate* in Islington; *Changes in Common* in Greenwich; *North Fulham New Deal for Communities* in Hammersmith & Fulham; *Neighbourhood Management Team* in Haringey; *Springfield Community Flat* in Lambeth; *City Gateway* in Tower Hamlets; and *Canning Town & Custom House Regeneration Project* in Newham. The co-hosts in phase two included the *Acton Community Forum* in Ealing; the *Peckham Voluntary Sector Forum* in Southwark; *Health, Adult and Community Services* in Barking & Dagenham; *Queens Crescent Community Centre* in Camden; *Tenant Involvement Unit* of Enfield Homes in

Enfield; *Woodberry Down Regeneration Team* in Hackney; *Groundwork Thames Valley* in Hounslow; *Kensington and Chelsea Social Council* in Kensington & Chelsea; *Bellingham Community Project* in Lewisham; *Forest YMCA* in Waltham Forest; and *Queen's Park Forum* in Westminster.

4.4.2. Well London Projects

The WL portfolio of projects suggested in the WL bid aimed to tackle health and wellbeing issues associated with healthy eating, physical activity and mental wellbeing in deprived communities in London. There were also a number of sub-themes of the programme, including healthy open spaces, and creative culture and arts. The projects aimed to improve health and wellbeing through:

a) Increased opportunities for and uptake of healthy eating choices; including enhanced access to affordable healthy foods and increased consumption of healthier food choices.

b) Increased opportunities for and levels of physical activity, and opportunities for local people to be more active.

c) Improved mental health and wellbeing; a more positive community perspective on mental health; tackling stigma and promoting mental health.

These projects were pre-conceived, at least in their general terms, at the stage of the grant application to the Big Lottery Fund. The WL alliance partners designed these projects based on their areas of expertise. The purpose of the CEP was to get to know the communities better and build relationships which would enable the programme understand the local needs and modify the portfolio of projects tailored to the specific community priorities. Therefore, it was envisaged from the start that these projects would undergo some re-designing following the CEP, and one of the objectives of this study is to examine how, and to what extent this has happened or otherwise. The list of 14 projects below represents the original portfolio of projects as submitted in the WL bid. All projects in the original portfolio were divided into two broad groups – the 'heart of the community' projects and the themed projects.

The 'heart of the community' projects are six community-led projects aimed at delivering community training, consultation and engagement, and ensuring access to the themed projects. These projects included: Consultation, Assessment, Design, Brokerage and Enterprise (CADBE); Well London Delivery Team (WLDT); Youth.com Unity; Active Living Map; Training Communities; and Well London Learning Network (Wellnet). The 'themed projects' are the eight theme-specific projects which include: Activate London; Buy Well; Eat Well; Changing Minds; DIY Happiness; Mental Wellbeing Impact Assessment (MWIA); Healthy Spaces; and Be Creative, Be Well. These projects and their delivery partners are described in appendix I.

Figure 4.3 illustrates how the 'heart of the community' projects relate with the themes of the WL programme and the expected process and programme outcomes.

Figure 4.3 - 'Heart of the Community' projects with the themes and aims of the WL programme. *Source: Well London (2007)*
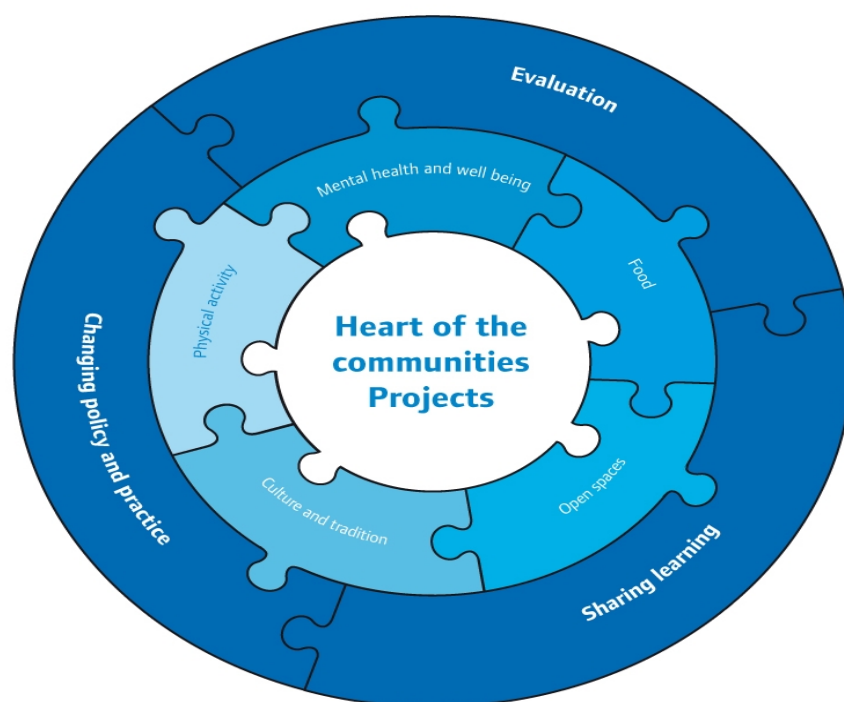
The expected outcomes of these projects, as reported in the bid (2007) were: a) 5,176 beneficiaries (about 30% of target population) having improved mental wellbeing and a more positive community perception of mental health and wellbeing; b) 4,602 beneficiaries comprising 3,424 adults and 1,178 children

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(about 27% of target population) having increased uptake of healthy eating choices, including enhanced access to affordable healthy foods; and c) 4,348 direct beneficiaries having increased levels of healthy physical activities. In addition, the programme was expected to make significant contributions to knowledge and policy of effective community engagement, and promote the dissemination of the model of community engagement across sectors in London.

4.4.3. Well London Funding

The Big Lottery Fund awarded the WL alliance £9,460,000.00 from its 'Wellbeing Fund' in July 2007. This funding was provided over a four year period (2007 – 2011) with each community receiving about £100,000.00 per year for three years for the delivery of a portfolio of health promotion projects. Funding for the evaluation of the programme was supplemented by the Wellcome Trust. A detailed breakdown of funding by partners and thematic areas is presented in table 4.7.

Table 4.7 –WL alliance partners' resources' packaging

Partner	Resources and Packaging of Resources
SLAM	• 'DIY Happiness' – Each SOA has £27,000 over 3 years [£5,000 in 1st year, £10,000 in 2nd year and £12,000 in 3rd year. There is enough funding available for 20 LSOAs. Local people bid into the fund and do anything that targets health and wellbeing. • £1,000 per LSOA for DIY Happiness kit for the community. • MWIA – Training a group of 5 people in each area – Training Communities. £1,000 per MWIA for undertaking the assessments (venue, refreshments and expenses) • 'Changing Minds' – Training around mental health awareness (de-stigmatising mental illness). £6,000 per SOA for delivering the training. Mental health service users will be trained. • 'Training Communities' - £366,000 for all 3 years of the project. Includes WLDT, personal support and capacity building. • Human resources – will employ project manager, administrator and training co-ordinator. • 'Can money buy happiness?' play/drama/musical - £2,800 per LSOA.
LSx	• Wellnet – Local and London-wide events. • Wellnet local events - £4,000 per LSOA for 3 years (e.g. to host meetings etc.) • Wellnet London-wide events - £36,000 per LSOA over 3 years, £32,000 for the website and e-bulletin. • 'Buy Well Eat Well' - £21,000 per LSOA over 3 years for 10 LSOAs. • 'Buy Well' – Pays for a worker to sit on committee (London Food Link Committee) - £213,000 over 3 years (expert post).
YMCA	• Youth.Com – 2 staff for 2 years to run events. • £2,000 per LSOA for 3 years. • 'Activate London' – 4 full time activators for 10 LSOAs • Specialist skills - £5,000 per LSOA per year.
ACE-L	• £1.26 Million • £200,000 for 2 full-time workers • £10,000 per LSOA for community cafe activities. • £12,000 over 3 years for steering and evaluation. • £15,000 over 3 years for Celebrations events. • £14,500 per LSOA per year for commissioning arts projects (Be Creative Be Well)
Groundwork	• £59,000 per year per Groundwork area (South, North, East and West) • South London – Per LSOA: £5,000 in 1st year, £10,000 in 2nd year and £11,000 in the 3rd year.
LHC	• £900,000 over 4 years. • Employ 3 core staff. • Evaluation, communications, overheads and public relations. • £16,000/year for communications.
UEL	• CADBE – 3 full-time staff. • £161,000 for cafés, payment of co-hosts and community engagement. • £7,452 for website. • £31,500 for social enterprise start up. • £174,000 for multimedia documentation (in partnership with ACE-L). • On-going focus groups in communities. • £50,000 per year for monitoring and evaluation. • £100,000 for baseline and follow-up surveys in year one and four respectively. • Association with LERI, Child Psychology Department, Schools for Architecture and Visual Arts in the University of East London.

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Chapter 5 – Methods

5.1. Introduction

This chapter presents the research design and methods used for collection of empirical data in this study. As this research used a multi-method approach, each research method will be described separately in terms of sampling, research tools, data collection and data analysis.

5.2. Aims, Objectives and Research Questions

The aim of this study was to evaluate the impact of the Well London (WL) community engagement process (CEP) on the development, content and delivery of local health promotion interventions and on the communities and stakeholders involved in this process. The specific objectives are presented in chapter one, section 1.3.2.

This research specifically seeks to answer the following questions:

1. What is the current framework of best practice for community engagement in the design and delivery of health promotion interventions?
2. What are the incentives and barriers to community engagement?
3. How can barriers to community engagement be overcome and the costs to communities met?
4. How does the community engagement process influence the overall fitness for purpose of the intervention design (both positively and negatively)?
5. How do these vary according to the type of issue to be addressed and the type of intervention envisaged?

6. How can community participation be delivered in a way that empowers the local communities and in a way that directly promotes their wellbeing?

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5.3. Research Design

The choice of the research design and methods was informed by the research questions. As the research addressed a range of questions, a mixed method approach utilising a range of data collection techniques was thought to be most appropriate.

5.3.1. Mixed Method Approach

A mixed method approach uses any mix of qualitative and quantitative methods, and involves the collection and analysis of various types of data (Brannen, 2005). The proponents of the approach argue that mixed methods help to develop research in a more comprehensive and complete way and allow for the use of supplemental data; while critics suggest that this research may be less rigorous and more difficult to interpret (Tashakkori & Teddlie, 2003).

The researcher is among those in favour of this approach, as in this specific study, the approach allowed a) asking a range of diverse research questions; b) ascertaining a more comprehensive picture of the CEP; c) documenting perspectives of multiple stakeholders; and d) triangulating findings obtained through different data collection methods. This approach allowed for an expansion in the breadth and range of enquiry.

The methods used in this research were: a) a literature review; b) questionnaire-based surveys of community events participants and WL partners; c) participant observation of the community engagement events; d) qualitative interviews with residents, local co-hosts, and WL alliance partners; and e) using evidence from documentary sources.

The literature review on health, health promotion and community engagement are presented in chapters two and three. This chapter will look at other methods used in the study.

There are two important aspects in the application of mixed methods - sequencing and dominance of methods applied (Morse 2003, 1991; Morgan, 1998). Qualitative approaches were dominant in this study because the study focused on the experiences of the community engagement events by different stakeholders, and their thoughts and feelings about the process and its impact.

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Qualitative methods drove the exploratory inductive thrust of this study (Tashakkori & Teddlie, 2003). In terms of sequencing, the surveys were conducted at the same time as participant observation of the events; and both preceded qualitative interviews and ==examination of evidence from documentary sources==. An evaluation survey of WL partners and co-host organisations was conducted between the two phases of the CEP.

Table 5.1 below shows the relationship between the research questions and the methods were used to answer these.

Table 5.1 – Research methods mapped against research questions

Research Questions	Research Methods
1) What is the current framework of best practice for community engagement in design and delivery of health promotion interventions?	• Literature Review
2) What are the incentives and barriers to community engagement?	• Literature Review • Questionnaire-based Surveys • Qualitative Interviews
3) How can barriers to engagement be overcome and the costs to communities met?	• Literature Review • Questionnaire-based Surveys • Qualitative Interviews
4) How does the community engagement process influence the overall fitness for purpose of the intervention design (both positively and negatively)?	• Participant Observation • Qualitative Interviews • ==Evidence from Documents==
5) How does the community engagement process vary according to the type of issue to be addressed and the type of intervention envisaged?	• Participant Observation • Qualitative Interviews • ==Evidence from Documents==
6) How can community participation be delivered in a way that empowers the local communities and in a way that directly promotes their wellbeing?	• Participant Observation • Questionnaire-based Surveys • Qualitative Interviews

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5.3.2. Study Areas

The choice of the areas for this study was largely opportunistic and determined by a number of factors. First, as the researcher worked single-handed she could not attend community events in all 20 WL areas; therefore the survey and participants observation could be conducted only at those events that she personally attended. Second, the data collection had to be blended into the CEP in ways which were neither disruptive nor intrusive. Therefore, similar to other community development studies, this research was driven by the data collection opportunities available within the CEP. Third, in some data collection methods (questionnaire-based survey and qualitative interviews), the researcher approached participants in different areas but not all areas responded equally; and the data could be collected only from those who volunteered to participate.

In total, 18 WL areas were included in this research, that is, where at least one data collection method was applied. However, due to the reasons explained above, not all methods could be applied in all areas. The areas where most methods were applied are: Barking and Dagenham; Ealing; Greenwich; Hackney; and Southwark. Table 5.2 shows all the WL areas where data for this study was collected and the methods applied in each area.

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Table 5.2 – Areas mapped against data collection method

Areas	Data Collection Methods							
	Surveys			Participant Observation			Q. Interview	Doc. Anal.
	Cafés Q1,Q2	CAWs Q3	Co-host Q4	Cafés	CAWs	PIMs		
Barking & D.	✓	✓		✓	✓	✓	✓	✓
Brent	✓		✓					
Camden	✓							✓
Croydon	✓		✓					
Ealing	✓	✓		✓	✓	✓	✓	✓
Enfield	✓			✓				
Greenwich	✓		✓	✓	✓			✓
Hackney	✓	✓		✓	✓	✓	✓	✓
H. & Fulham				✓				
Haringey	✓							
Islington	✓							
Lambeth				✓				
Newham	✓			✓				
Southwark	✓	✓		✓	✓	✓	✓	✓
Waltham F.	✓			✓				✓
Westminster	✓	✓			✓			✓

5.4. Questionnaire Surveys

Four independent questionnaire-based surveys were conducted as part of this research. These were surveys with community café participants in phases one and two (Q1 and Q2); a survey with CAW participants in phase-two (Q3); and an open-ended question evaluation survey of the WL alliance partners and co-host organisations following phase-one CEP (Q4).

5.4.1. Sampling and Recruitment

It was intended that the survey of community engagement participants would take place in all community cafes and CAWs, and in as many WL areas as possible. However, as the researcher was single-handed, and the CEP was organised within a relatively short period of time and within a tight schedule, it was physically impossible to attend all the events in all the areas. Community

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café surveys were conducted in six of the nine phase-one boroughs (Brent, Croydon, Greenwich, Haringey, Islington, and Newham); and eight of the 11 phase-two boroughs (Barking & Dagenham, Camden, Ealing, Enfield, Hackney, Southwark, Waltham Forest, and Westminster).

The survey of CAW participants could be conducted in phase-two only and involved five of the eleven boroughs (Barking & Dagenham, Ealing, Hackney, Southwark, and Westminster). Survey Q4 involved WL partners and three of the nine co-host organisations who participated in phase-one CEP (Brent, Croydon, and Greenwich).

The process of participant recruitment in surveys Q1, Q2 and Q3 was similar. Participants who attended the cafés and CAWs were told about the survey and its purpose at the end of each event and were invited to complete a questionnaire. In total, 59, 75 and 63 questionnaires were returned in surveys Q1, Q2 and Q3, respectively (table 5.3).

Table 5.3 – Numbers of completed questionnaires and community events

Community Event	Study Population	Number of Boroughs	Number of questionnaires completed
Community cafes (1st phase) Q1	Community members	6	59
Community cafes (2nd phase) Q2	Community members	8	75
Community action workshop Q3	Community members, local voluntary and statutory organisations	5	63
			197

Overall, 14.3% of all phase-one café participants and 16.2% of all phase 2 café participants participated in the surveys. These proportions ranged the wide range and cannot be strictly regarded as a response rate in most areas because the survey was sometimes conducted at one of the two cafes only. The proportions of those who participated in the surveys ranged from as low as 19% in Westminster to as high as 78% in Barking and Dagenham (Table 5.4).

Table 5.4 – Response rate for community café survey Q2

Borough	No. of workshop participants	No. of completed questionnaires	% Response rate
Barking & Dagenham	18	14	78
Camden	19	7	37
Ealing	49	14	29
Enfield	29	7	24
Hackney	30	13	43
Southwark	37	10	27
Waltham Forest	16	4	25
Westminster	32	6	19
Total for these areas	230	75	33

There were a number of factors which affected a relatively low response and variations in the responses between the areas. First, the surveys at the majority of the events were announced at the end of the meeting when some participants had already left and many were in a hurry to leave. Although reasonable efforts were made to approach these participants as they were leaving, some declined to participate. In a few cases, the survey was announced by the facilitator as part of the overall programme of the event; and in these areas, the response was better. Furthermore, the cafés did not always follow the World Cafe agenda because in some areas there were not enough participants to hold group conversations. The programme of events had to be altered to accommodate a different mode of consultation. And in some areas (for example Southwark), the café followed a very flexible format where participants would come and go, or arrive and leave at different times. In these areas, it was difficult to get enough participants at any one time to introduce and describe the survey. The participants had to be approached individually, often at the time when they were leaving; as a result many participants were missed out or could not be followed up to collect the questionnaire. Of those who were approached to complete the questionnaire, two participants each in Barking & Dagenham, Ealing and Enfield declined to

complete the questionnaires; their reasons were mainly that they were in a hurry and were time-constrained because of work or family commitments. One of the two refusals in Enfield was a lady who did not have her reading glasses with her and so could not see to sign the consent form and complete the questionnaire. One person declined to complete the questionnaire in Southwark; there were no refusals in Hackney and Waltham Forest. There is also some evidence to suggest that in some areas, the total number of attendees included children who had accompanied their parents. The survey, however, included mainly adult participants over 16 years of age.

Survey Q4 was an evaluation of the phase-one CEP to get feedback and identify lessons for phase-two. This survey involved all WL partners and co-host organisations for the community events in phase-one. The questionnaire was e-mailed to all seven WL partner and all nine phase-one co-host organisations. Six WL organisations (85.7%) and three co-host organisations from Brent, Croydon and Greenwich (33.3%) returned the questionnaire.

5.4.2. Research Tools and Data Collection

The questionnaires used in the café surveys were developed by the researcher but included a number of questions from national surveys such as the Home Office Citizenship Survey, 2003: People, Families and Communities Survey (Research Study 289); and the European Social Survey (ESS). The questionnaire used in phase-one (Q1) had sections on demographics, health and wellbeing, and community involvement; it was subsequently modified, as phase-one was used largely as a pilot study. The phase-one questionnaire is attached in appendix IV. Provisional analysis of the phase-one data required that some questions be reworded, clarified or modified in other ways. The modified questionnaire used in phase-two (Q2) is attached in appendix V, and contained 38 multiple choice and open-ended questions in the four sections of the questionnaire as follows:

a. About You –12 socio-demographic questions.
b. Your Health and Wellbeing – eight questions about general health and wellbeing, disability and self-reported level of happiness and coping.

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c. You and Your Community – six questions about the level of satisfaction with the community and neighbourhood, level of safety in the community and involvement in the community and community activities.

d. About the Community Café – 12 questions about the WL café specifically, including participants' expectations, experiences and the likelihood of future participation in similar events.

At the end of the questionnaire in phase-two, respondents were asked whether they were willing to be contacted for further in-depth discussions for research purposes, and if so, to give their names and contact details. Those who gave their details were contacted later and invited to participate in the qualitative interviews.

The questionnaire used in the CAW survey (Q3) had three sections. The first section asked about the expectations and experience of the workshop; the second section started with a filter question asking whether the participant was a community resident or a representative of a stakeholder organisation. Residents completed six further questions which asked about their socio-demographic characteristics; and representatives of stakeholder organisations were asked to go to the third section where there were four questions about their organisations and their roles. The questionnaire used can be found in appendix VI.

In the Q3, 63 questionnaires were completed in five boroughs. Thirteen of the 63 respondents identified themselves as residents of the communities; five of these also represented organisations as well as being residents. Forty-three respondents (Barking & Dagenham-1; Ealing-14; Hackney-8; Southwark-6; Westminster-13) consented to be contacted for further discussions. None of the participants declined to complete the questionnaire surveys in Barking & Dagenham and Ealing. One participant in Westminster and three participants in Hackney declined; they said that they were in a hurry to leave the event. Note was not taken of the number who declined to complete the questionnaire survey in Southwark.

The Q4 survey was wholly developed by the researcher and was e-mailed to the seven WL alliance partner organisations and nine co-host organisations that in the first phase of the CEP. A reminder email was sent weekly for three consecutive weeks. All WL alliance partners (except SLAM) and three

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community organisations for Brent, Croydon and Greenwich completed and emailed back the questionnaire. The questionnaire required the organisations to evaluate the process by answering open-ended questions on the organisation, usefulness, participation and barriers of the phase-one CEP and make proposals for improvement. Questionnaire is attached as appendix VII.

5.4.3. Data Analysis

The data from surveys Q1, Q2 and Q3 were entered into Microsoft Excel® and then transferred to IBM® Statistical Package for Social Sciences (SPSS®) software for analysis.

As the Q1 was modified and therefore slightly different from the Q2, only those questions that were similar in both surveys were combined for the purpose of analysis. Descriptive statistics was used to describe survey participants in terms of their socio-demographic characteristics; and organisational representation (survey Q3). It was also used to examine the frequencies of the main survey variables; satisfaction with the CEP; responsiveness of the CEP to the needs and expectations; and self-reported barriers and ways to overcome these. Cross tabulation was used to present the distribution of the key outcome variables by participant characteristics (socio-demographic, health, community involvement).

Quantitative analysis was done by calculating mean, median and percentages of continuous variables such as ages of respondents, length of stay in the UK for those born outside the UK, and length of stay in neighbourhood for all respondents.

The results of the two samples of observations from this study and the WL survey were compared using the Mann-Whitney U test (or Wilcoxon rank-sum test), a non-parametric statistical test which measured the central tendencies of the two samples, that is, their mean and median values. This test was chosen because the distribution was not normal.

Another non-parametric test used was the Kruskal-Wallis one-way analysis of variance, an extension of the Mann-Whitney U test. This was used to test whether the samples from the two surveys originated from the same distribution.

Qualitative data analysis for the surveys is attached as appendix XV.

Qualitative data from open-ended questions in surveys Q1, Q2 and Q3, and responses from survey Q4 were manually analysed thematically by developing a set of codes and sub-codes for the narrative responses. All narratives and responses were grouped in relevant themes and sub-themes in Word® documents.

Results of the questionnaire surveys were primarily used to describe the characteristics and perceptions of the community residents, community organisations and the WL alliance organisations, respectively in chapters seven, eight and nine.

5.5. Participant Observation

Participant observation was conducted during community cafes, CAWs and project implementation meetings. The main purpose of the participant observation in this study was to provide a detailed and systematically recorded description of the engagement events, the dynamics, interactions and the overall atmosphere. Participant observation is viewed as an important part of qualitative research as it depicts the scene, emotions, and feelings as perceived and interpreted by the researcher, who participated in the activity being observed (Ritchie & Lewis, 2003). Methodology literature on participant observation suggests that it is imperative to keep a record of both objective and subjective observations, and that participant observation should take place around three primary components - a place, actors and activities (Ritchie & Lewis, 2003). Participant observation makes use of ethnographic questions which are descriptive and provide a broad overview of the situation, describing who was there; what they were doing; what the physical setting of the social situation was; what it felt like to be part of that scene.

There are different levels of participant observation depending on the level of participation of the observer. In this study, the researcher was an active participant as she was part of the engagement team and was involved in both the CEP planning and delivery. At the same time, the records on the days of

observation were collected in a structured and systematic way focusing on specific areas of observation and using pre-designed observation template.

<mark>The participants at the community events were aware of the researcher's presence as the facilitators informed them of the research and requested their cooperation.</mark>

5.5.1. Sampling

Participant observation was conducted at the community events which the researcher could attend personally. However, observations during phase-one cafés were used largely for understanding the community scene and for developing and piloting the observation tool. The observation at these cafés did not follow the same format as at the subsequent events and therefore were excluded from the analysis. The CEP was observed during six cafes in phase-two (Barking and Dagenham, Ealing, Enfield, Hackney, Southwark and Waltham Forest); five phase-two CAWs (Barking and Dagenham, Ealing, Hackney, Southwark and Westminster); and four PIMs (Barking and Dagenham, Ealing, Hackney and Southwark). Two phase-two cafes were attended by the researcher and surveys at those cafés were completed but the logistics of the event did not allow for any structured observations in those areas (Camden and Westminster).

In addition, the researcher attended and observed a consortium portfolio workshop event which brought together all WL alliance partners, and discussed the distribution of resources and projects across all WL areas.

5.5.2. Research Tool and Data Collection

Overall, the CEP in the selected LSOAs was observed over a period of one year between October 2007 and September 2008. Phase-one observations were used to develop, pilot and refine a tool for systematic recording of the observed data. <mark>During the participant observations of the phase-one community events, the researcher noticed that there were certain factors which affected participation, interactions and response to the survey (such as the co-host information and relationship with the community; skill of the facilitator; whether the research was introduced or not; and specific features of each borough which may contribute to the event). These factors were</mark>

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A protocol was developed by the researcher and focused on the following:

1. Background Information:
   a) Type of community engagement event – community cafe, community action workshop, project implementation workshop.
   b) Information about the area – name of borough, name of LSOA, co-host organisation and contact person, and WL lead partner.
   c) Information about the event – date and time, address of the venue.

2. Observations:
   a) Weather conditions on the day
   b) Venue – accessibility, location, lighting, ambience, crèche or play facilities, exhibition.
   c) Participants – estimated number of participants, observed demographics (age range, gender, and ethnicity).
   d) Interactions – interests in the discussions, participation in activities, engagement and feedback, issues of particular interest, group dynamics and the facilitation quality.
   e) Survey – introduction; interest; participation; number of completed questionnaires, number of refusals and reasons for refusal.
   f) Event specificity – special features or peculiarities of the event which may differentiate it from other areas; or something that happened during the event which deviated from the norm.

Handwritten notes were taken using a template. Artefacts from the events such as pictures, maps, invitation posters and flyers were collected to add detail to the observation notes. Consent was not taken for the participant observations; several authors argue that consent for undertaking participant observation is unnecessary because it is difficult to determine who to seek consent from as the whole group of participants are observed (Richie & Lewis, 2003; Spradley, 1980).

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5.5.3. Data Analysis

Participant observation notes were analysed thematically by assigning codes and sub-codes to the text and searching for patterns, similarities and differences across the observations. Each field note was analysed immediately after the event in order to know what to look for during the next session of participant observation.

Results of the participant observation are presented in chapter six; and describe the target neighbourhoods, the attendance at the community events, participants, timing, facilitation, exhibition, and response to completion of survey.

5.6. Qualitative Interviews

The purpose of the qualitative interviews was to focus on individual participants and provide an opportunity for detailed exploration of participants' personal experiences, feelings and perceptions of the engagement events. The interviews also provided an opportunity for an expression of participants' emotions and thoughts, as they could talk about the issues that were important to them and the matters they felt strongly about. Academic literature suggests that application of such in-depth methods is crucial for explanation and evaluation of new events, experiences and situations, as these methods have the capacity to describe and interpret in a comprehensive and responsive manner (Chestnutt et al, 2003; Hammersley & Atkinson, 1995; Oppenheim, 1992; Webb & Webb, 1932).

This study used a semi-structured interview technique so that information essential to the study were obtained from the respondents while giving them the opportunity to elaborate on the issues that mattered to them. In giving them this opportunity, some unanticipated information were obtained which helped the evaluation of the CEP; and this would not have been possible if the interviews had been conducted in a strictly structured manner. Also, the semi-structured nature of the interviews allowed the researcher to maintain the direction of the discussions and focus on the issues at hand, especially when the respondents deviated from the topics; it also helped to ensure that all the

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5.6.1. Sampling and Recruitment

Participants for qualitative interviews were recruited in two ways, using the elements of purposive and convenience sampling. First, all participants of the phase-two cafés and CAWs who participated in the surveys were asked at the end of the questionnaire whether they wanted to be contacted for further in-depth research. Those who said 'yes' and provided their contact details were contacted six to nine months later for an interview. Fifty-two of the 75 Q2 respondents indicated that they could be contacted for an interview. However, seven of these did not provide a telephone number. All the respondents who provided their number were telephoned and invited to participate in a face-to-face qualitative interview. Seventeen of those telephoned could not be reached on the numbers given; 14 declined to be interviewed for reasons of ill-health, time constraints or lack of interest in the programme, and two people said that they no longer lived in the area. The 12 participants who agreed to take part and were interviewed lived in four phase-two LSOAs (Barking & Dagenham, Ealing, Hackney, and Southwark).

Secondly, one to two identified members of each WL organisation and each co-host organisation in phase-two CEP were approached by telephone and invited to take part in an interview. All 15 of the WL partner representative and six co-host organisations' staff approached agreed to be interviewed.

In total, 33 qualitative interviews were completed in this study (Table 5.5).

Table 5.5 - Number of qualitative interviews done

Participants of Qualitative Interviews	Number
Community members who attended community cafes	12
Well London Alliance partners	15
Community organisations who acted as co-hosts	6
Total	33

Sample size for qualitative studies involving qualitative interviews often rest below 50. It was important to keep the sample size to a manageable number because if it exceeded 50, the study would become difficult to manage in terms of the quality of data collected, and the analysis that could be accomplished (Ritchie and Lewis, 2003). The sample was not intended to be statistically representative since purposive sampling was used.

5.6.2. Research Tools and Data Collection

Three topic guides, one for each group of participants, were developed for the interviews (appendices VIII: a, b, and c) and were used to ensure that all relevant areas and themes were covered; but the participants were given an opportunity to pursue their own themes of interest. The topic guides helped improve the uniformity of data collection and ensured that important issues were covered systematically and with some consistency, whilst still allowing some flexibility to pursue the aspects that were important to each individual participant (Burgess, 1984). Questions in the topic guides were open-ended and required descriptive answers.

All interviews were conducted face to face; combined some structure with reasonable flexibility; and were interactive in nature and allowed for a discussion rather than a 'question and answer' session. In each interview, the researcher employed a range of probes which allowed more in-depth in explorations. All interviews were audio-recorded with some written notes taken to complement the recording.

The interviews with the residents took place in their homes (7), community halls/centres (4), and a local café (1). The interviews with the WL partners and co-hosts took place in the offices of these organisations. The average length of an interview was 27 minutes; but there was a wide time range in the interview time with the shortest interview lasting eight minutes and the longest interview lasting 61.41 minutes.

5.6.3. Data Analysis

The interviews yielded 886 minutes of audio-recording. The audio-records were transcribed verbatim to Microsoft® Word and used for document preparation; and then uploaded to NVivo 2.0® which was used for storing the data

electronically, and organising data in a structured framework to enhance traceability. This version of the software is an older version but was used because it was readily available for the researcher's computer operating system, inexpensive and had the necessary features needed for the analysis of this study.

A thematic analysis was done using pre-determined themes as nodes, but some new ones were created when new themes or sub-themes emerged during analysis. All interviews were kept under the same project but each interviewee was made a case with its own attributes such as age, occupation, community, and organisation. The cases were then grouped under the three main groups - community residents, community organisations and WL partners. Nodes were created which represented the main themes of the study (perceptions, barriers and challenges, incentives, impact of CEP, community) and the relevant data were coded under each node/theme (Figure 5.1). A node tree was then created which contained a logical composition of similarly themed nodes arranged in hierarchy.

Figure 5.1 – NVIVO node coding report

NVivo revision 2.0.163 Licensee: Olamide Sadare User: Administrator Date: 11/01/2010 Project: COMMUNITY ENGAGEMENT NODE CODING REPORT Total Number of Cases: 33					
Node **(Themes)**	**Description of Node**	**No of cases in node**	**No of cases - residents**	**No of cases - CVO**	**No of cases - WL Partners**
Perceptions of the WL CEP	What are the perceptions of the WL CEP - strengths, limitations and opportunities?	29	11	5	13
Incentives and Benefits of CEP to communities	What do the residents, CVO and WL partners think are incentives for the communities to encourage participation? What are some of the benefits that communities may derive from the CEP?	32	12	5	15
Incentives for WL partners and CVOs	What are the incentives and opportunities for the Well London partners and CVOs in undertaking CEP?	14	n/a	4	10

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NVivo revision 2.0.163   Licensee: Olamide Sadare
User: Administrator   Date: 11/01/2010
Project: COMMUNITY ENGAGEMENT
NODE CODING REPORT

Total Number of Cases: 33

Barriers and Challenges of CEP	What are the Challenges and Barriers to Community Engagement from the perspectives of the community residents, CVO and WL partners?	33	12	6	15
Lessons Learnt from the WL CEP	What are some of the lessons learnt that could make community engagement better and more effective in the future processes?	23	2	6	15
Inter-organisational working in the WL CEP	How well did the WL partners work together? What were the challenges and opportunities of inter-organisational collaboration in CEP?	19	n/a	4	15
Well London Projects	Knowledge of the WL projects and a description of some of the projects that have been designed and delivered to the intervention communities	19	6	5	8
Influence of CEP on the Design and Delivery of Projects	What influence has the WL CEP had on the design and delivery of the Health Promotion Interventions in the intervention communities?	16	n/a	2	14
What does "Community" mean to you?	Describes different views and perspectives of what community residents believe 'community' means for and to them	10	10	n/a	n/a
Ways of Communicating with Community	By what means do people want to be engaged? How can information be effectively passed on to the community?	26	11	3	12
Current Framework for Community Engagement	What are the current approaches used to engage communities? How have organisations engaged communities in the past?	20	5	5	10

The themes and ideas captured and linked in node trees were used to create node summary reports to include node description and coding details. The reports were exported to Word® and then used for writing up results under each theme.

5.7. <mark>Evidence from Documentary Sources</mark>

The purpose of <mark>examining evidence from documentary sources</mark> was two-fold; first, to complement the survey and qualitative interview data in order to better understand the process of CEP, the challenges it faced, the opportunities it gave to the communities and other stakeholders, and the experiences of those who were involved in the CEP design and delivery. The second aim was identify and systematically review the changes in the portfolios of interventions which have or have not occurred as a result of the consultation process, and to which extent these changes reflected the community needs expressed in the programme and area documentation. The analysis of challenges, experiences and opportunities was done across all WL areas; the analysis of project portfolio focused on the selected number of LSOAs. These were eight purposefully selected LSOAs which were the primary focus of this research and where most data collection methods were applied. These were all phase-two LSOAs (Barking & Dagenham, Camden, Ealing, Hackney, Southwark, Waltham Forest, and Westminster), except Greenwich.

5.7.1. Selection of Documents for Analysis

The documents included in the analysis were selected purposefully, as these were the documents written for the WL programme or target areas; and they described the areas, the process of CEP and the portfolio of the projects at different stages of the programme. The documents were obtained from the WL and borough websites, the CEP delivery team, and the WL delivery partners. These documents included the project bid submitted to the Big Lottery Fund (BLF); WL official quarterly monitoring reports (QMR) to the BLF; local area agreements (LAA) for the target boroughs; and the café, CAW and PIM documents which outlined the issues and needs as expressed and discussed at the community engagement events, and the project plans for each area.

5.7.1.1. Project Bid to BLF (Well London Strategy)

The WL bid to the Big Lottery Fund was written by the alliance organisations. The bid outlines a variety of health promotion interventions proposed for the disadvantaged areas. The document gives an introduction to the WL programme as perceived by the alliance; and information on the needs assessment carried out during the bid development stage, and how the

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proposed portfolio of projects can address these needs. The bid proposed to use a community development approach and to work at a grass-root level to a) increase levels of healthy eating and physical activity; b) focus on children and young people's involvement, health and wellbeing; c) improve general mental health and wellbeing; d) create and improve healthy green spaces; e) mobilise and use culture, arts and tradition to promote wellbeing; and f) enhance community capacity and cohesion.

5.7.1.2. Well London Quarterly Monitoring Reports (QMR)

These are reports and forms submitted at the end of every quarter of the grant period. The reports were written by the WL alliance partners and sent to the BLF. Each report discusses the activities delivered in a given quarter, the progress on individual projects, and how they contributed to the expected outcomes; the challenges experienced in the reporting period; staffing, finance and communication issues, and plans for the next quarter. All reports were authorised by the Greater London Authority (London Health Commission) on behalf of the WL alliance.

In total, five reports covering the periods October 2007 to March 2009 were included in this study.

5.7.1.3. Local Area Agreements (LAA)

Local area agreements are three-year action plans agreed by the central government and local authorities for improving local communities. The LAA were introduced in 2004 by the Labour Government as a way of giving local communities more influence and power in improving their own lives (DCLG, 2006). LAAs were developed by local authorities with their local partners, police, health authorities, local businesses and community groups, who are part of the local strategic partnerships (LSP). An LAA is an area-plan of 35 indicators selected from a set of national and local performance indicators which each LSP agrees as priority targets relevant to their area. The LAA used for this analysis are the 2008-11 documents.

However, LAAs were abolished in October 2010 by the Coalition Government; but they were relevant local policy documents at the time of this research and therefore were included in the analysis.

5.7.1.4. Community Engagement and Project Implementation Documents

In the period between the cafés and the CAWs, the café notes taken by scribes at the events were pulled together and café discussion transcripts were written for each LSOA. These notes were analysed thematically by the CEP delivery team. The themes formed the basis for the area documents presented at the CAWs.

The CAW documents were the booklets written by the CEP delivery team and the borough leads together with the co-host organisations. The booklets were distributed to the residents and local stakeholders prior to or on the day of the workshops. Each booklet contained the CAW agenda, information about the WL programme, mapping of the existing local services and amenities, a pen-profile of the area, and the themed summaries of the community café discussions.

The project implementation documents (PIDs) were written by each borough lead organisation, who also presented it at the PIMs. PIDs contained a comprehensive list of the projects that would be delivered in each area, the objectives of the projects, costs of delivery, who will deliver them, for how long, the target participants and the needs that the projects will address, the expected outcomes, and the issues around sustainability after the end of the WL programme.

5.7.2. Data Analysis

The analysis of the documents was done using a data extraction template which helped to extract relevant information about the document and the information relevant to the research questions in a coherent and systematic way (appendix IX).

The contents of the documents were analysed to obtain information about experiences, challenges, opportunities and impacts of the CEP. The relevant pieces of text were coded thematically, and the documents were then cross-examined to pull information across different documents and different themes. The links between the themes in different documents were established to depict the chronological development of that theme over time. For example, if a particular risk to the programme development was identified in the project

bid or in the first quarterly report, the text related to that risk was cross-examined and tracked in the subsequent documents to identify whether and how that risk was addressed or what the impact of the risk was.

To analyse the impact of CEP on the project portfolio, the documents were also analysed chronologically, and the data extracted from the documents included what the original project bid said about the portfolio of interventions for WL areas; how each area included in the analysis described their priorities in their LAA; how communities expressed their needs during the café consultations; how these priorities were reflected in the CAW documentation and in the subsequent portfolio of projects presented in the PID.

5.8. Ethics

Ethical approval for this study was granted by the University of East London's Research and Ethics Committee in 2007 (reference: ETH/07/64; appendix X). The study was also bound by the health and safety standards and the field work code of practice regulated by the UEL School of Health and Bioscience. A Health and Safety approval for the study was granted in June 2007 (appendix X).

Participation in the study was voluntary and based on informed consent. The survey participants were given information about the study during the events (appendix XI) and they had an opportunity to ask questions before completing the questionnaire, and after the event by contacting a named person at the UEL. All café and CAW survey participants gave their written consent before completing the questionnaire (appendix XII). Evaluation survey participants received information about the study by e-mail and completion of survey was taken as consent.

Consent was not taken for the participant observations, as it was not practically feasible, but all observations were anonymous.

The community residents invited for qualitative interviews were given information about the study on the phone, and they were given time to make a decision about participation. On the day of the interview, each participant

again received information about the study and the purpose of the interview. The participants again had an opportunity to ask questions about the content and format of the interview. They all received an information sheet which explained the study and signed a written consent form (appendices XIII and XIV).

Information to the co-host organisations and WL alliance partners was given over the phone when an interview was sought, and again on the day of the interview. They had an opportunity to ask questions. For these interviews, only a verbal consent was obtained.

All participants were advised that the data would be audio-recorded and transcribed, and were assured of confidentiality of their data and that no personal names would be disclosed.

Chapter 6 – Participant Observation of Community Engagement Events and Meetings

6.1. Introduction

This chapter presents observations of the researcher during the Well London (WL) community engagement events. The results are presented by the main themes describing the target neighbourhoods, community cafes, community action workshops (CAW), and programme implementation meetings (PIM).

6.2. Target Neighbourhoods

The target neighbourhoods were largely social housing estates with a diverse multicultural resident population. The areas were identified as disadvantaged, and they indeed exhibited a number of traits of physical deprivation such as the lack of green spaces, boarded houses, signs of high criminal activities, structural defects in buildings, graffiti, unkempt environments, lack of safe communal spaces and poor access to healthy foods and physical activities. Pictures 6.1 and 6.2 are typical examples of the areas within which the community engagement process (CEP) took place. Although the physical environment suggested that the areas were some of the most deprived in London, the researcher's interactions with and observation of the residents at the community events showed that the residents generally did not identify themselves or their communities as particularly poor or disadvantaged. They did acknowledge that things could be better; however their disposition was usually happy and they laughed and made jokes.

Some of the areas such as Barking and Dagenham, Ealing and Hackney were undergoing major regeneration projects as was evident from the construction works going on. It was also evident that the residents and local stakeholders were deeply affected by the regeneration which had created an air of uncertainty and appeared to be the major topic of discussion at the community events in these areas.

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Another noticeable feature in some of the observed areas such as Lambeth and Islington was the almost tangible political tensions between multiple stakeholders involved in the community events. Lambeth had multiple policy players engaged in health promotion issues and the borough was evidently embroiled in local political tensions which manifested in some stakeholders declining to participate in the events and some expressing their anger at not being the primary local organisation that the WL dealt with in the borough. Such competitive actions between multiple stakeholders made it difficult for WL to prioritise any one partner while the engagement of all groups at the decision-making table was not possible. In the case of Islington, there was an established network of community organisations and the role of WL in community development and civil participation seemed to be redundant compared to the other established programmes in the community. The local organisations were not very happy about an external one coming into their community and appearing to give them orders about how to engage their community.

Picture 6.1 – WL intervention area (I)

6.3. Community Cafes

The community cafes were observed in Brent, Croydon, Greenwich, Hammersmith and Fulham, Haringey, Islington, Lambeth, Newham and Tower Hamlets in the phase-one CEP. The observation of these cafes served as a pilot for the observation tool which was used for observation in phase-two cafes in Barking and Dagenham, Ealing, Enfield, Hackney, Southwark, Waltham Forest, and Westminster.

6.3.1. Facilities and Organisation of Events

The cafes were held in various indoor locations. The majority were in community or organisation halls (Barking and Dagenham, Ealing, Enfield, Hackney, Lambeth, Newham, Tower Hamlets and Waltham Forest). Other venues included Church halls (Brent and Croydon); co-host offices (Greenwich and Haringey); and a tenant association hall in Southwark.

The intention was to hold the cafes within the target areas. However, in Brent and Croydon, there were no suitable community spaces within the LSOA and therefore alternative venues just outside the areas were used. Many venues were easily accessible (picture 6.3) but the cafes in Haringey and Greenwich which were held in the co-host offices located on the first floor had no wheelchair access. Although no resident was identified as being unable to get to these cafés because of inaccessibility, it is likely that the residents already

knew the limitations of these premises; and the attendance of residents with disabilities in these LSOAs was poorer than in other areas.

Each target area except Tower Hamlets and Islington had two cafés held on the same day. The first cafe started late morning or early afternoon, and the second one started late afternoon or early evening. This was done so that the residents had a choice of two cafés to suit their work or other commitment schedules.

The venues were set up to look inviting and comfortable with chairs, tables, flowers and battery-operated candle lights. The rooms were such that whole group conversations could be held and participants could see and hear one another from any part of the room. The table cloths doubled as writing sheets for the participants to write down their thoughts or feelings. Picture 6.4 below shows a typical table set up.

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Most participants were satisfied with the venues; however, in Ealing, there were complaints about the quality of the acoustics which affected the whole group discussions because the participants found it difficult to hear one another.

Crèche facilities and refreshments were provided at all the events. The crèches were always welcomed and used by parents who had brought their children along for the events. Refreshments were also provided (picture 6.5) and many residents welcomed this; for example one lady in Southwark said that it was the thought of the free food that motivated her to come for the café. In a few cases, free food was not seen as an incentive as the narrative below suggests:

At the community café in Barking, a White British lady came in with her daughter. They were shown a food table. The woman declined any refreshment. She said that she had come to get things off her mind and wanted to get straight to the point. The refreshments provided were of little relevance to her.

There were several exhibition facilities during the cafes. These included an information exhibition, a computer-based planning-for-real booth, project videos, an interactive map display, a comments board, and a graphic artist corner (pictures 6.6, 6.7, 6.8 and 6.9). Picture 6.6 shows people participating in the interactive planning-for-real; two people by the interactive map display; and one person watching a project video.

Picture 6.6 – Community cafe exhibition

The exhibitions were mounted on eight feet vertical boards arranged along the periphery of the hall. Depending on the space available, six to ten of these boards were displayed, providing textual and pictorial information about the WL programme, specific themes, and potential interventions. There was staff

from each of the delivery organisations to provide information and answer questions about the interventions. Where space permitted, there was also a television screen showing videos of the projects.

The exhibitions helped to create a bright environment for the cafés and provide information about the WL projects. The residents had an opportunity to test the relevance of the WL programme for their specific neighbourhoods and estates. For example, at the interactive map, the residents could point out where they lived and trace the distances to project facilities and services (picture 6.7). They could also leave comments and suggestions on a blackboard (picture 6.8). A graphic artist present at the events captured the discussions, expressed needs and suggested solutions in a graphic illustrative form (picture 6.9). Many people praised the exhibitions and said they had fun testing the different tools.

Picture 6.7 – Interactive map display at a community cafe

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Picture 6.8 – Comments blackboard

Picture 6.9 – Graphic artist

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6.3.2. Attendance and Participation

The majority of cafés were well attended with a high level of participation in the activities and discussions. Ealing, Greenwich, Hackney, Hammersmith and Fulham, Southwark, and Westminster recorded very good attendance; but overall attendance varied from an estimated 5 to 40 participants per cafe. In all the areas, the first cafe (late morning/early afternoon) was better attended than the second one. The most frequently reported reason for that suggested by the residents themselves was the fear of going out in the dark. Interestingly, this was the same reason given at both the first phase cafés held in October and November and the second phase cafes held in May and June even though the days were longer in the later.

The attendance of the second phase cafés was better than the first phase ones. In the second phase, the co-hosts and WL leads used a variety of strategies to increase cafe attendance. In Barking and Dagenham, the co-host had organised a raffle draw for every resident who attended the café.

Weather conditions did not appear to affect attendance. For instance, the day of the cafés in Enfield was cloudy with heavy rain later, yet the café enjoyed a good attendance.

With a few exceptions, there was a wide range of age distribution of participants. In two boroughs, the involvement of community organisations focusing on older people (Age Concern in Hackney and Elders Voice in Brent) resulted in a higher proportion of participants from older age groups. Picture 6.10 shows an older group of participants at one of the cafes. The ages of the participants ranged from approximately 20 to 80 years. The cafes in Barking and Dagenham, Ealing and Southwark, had a relatively high number of young participants in their teens. At many cafes, the availability of crèches ensured participation of families with children; but often, children sat with their parents, and in Greenwich, some of the children acted as interpreters for their parents.

Ethnic distribution of the café attendees also varied. Several cafés (Ealing, Enfield, Southwark, Waltham Forest and Westminster) witnessed a mixed ethnic diversity including White British, Black Caribbean, North and West Africans, Chinese, South Asians and mixed race participants. Other cafés were dominated by one or another ethnic group. In Greenwich for example, the participants were disproportionately of Somali origin and the café sessions were interpreted in Somali. In Barking and Dagenham, the participants were largely White with only two Black, one mixed race, and no Asian participants.

With regards to gender, the café participants were predominantly female. In Enfield and Westminster, there were approximately two females per male participant. In Hackney and Ealing, the ratio was three to one. Only in Waltham Forest did the number of female and male participants appear to be equal. Picture 6.11 shows a typical gender ratio at the cafes (the man second from the left is not a participant; he is a WL partner staff taking notes of the discussions).

Further details of attendance and demographic information of participants are provided in chapter seven.

6.3.3. Discussions and Interactions

The discussion question was the same at all cafes – "What do you understand are the health needs of your community?" or "What do you understand about the health needs of your community?" It was deliberately agreed to keep the question broad and to give people an opportunity to discuss whatever their individual, family or community needs were. Occasionally, the facilitator tried to narrow down the discussions to physical activity, healthy eating and mental health, but people wanted to talk about wider issues such as on-going regeneration projects, quality of housing or problems with the local authority or council. Overall, the residents wanted their communities to share common goals, participate in social networks, remove the fear of crime and anti-social behaviours, and promote healthy and safe environments where everyone felt they belonged and their contributions were valued. The most commonly discussed themes were safety, intercultural and intergenerational social cohesion, and inclusiveness.

The cafes were unusual events for these communities; they gave the residents an opportunity to get together with neighbours to discuss in a relaxed, comfortable and informal social atmosphere. Close intercultural and intergenerational interactions between the participants were observed in the majority of the cafés. These interactions were not limited to the café discussions; they evidently extended to networking and socialising before and after the cafes. Participants were seen chatting and laughing together, discussing about the exhibition posters, getting food and drinks for each other, and looking after

each other's children. For example, the following scene was observed in Waltham Forest:

Two ladies got up to get more drinks at the refreshment table. One is a black North African; the other one is White British. They have just met and shaken hands; they introduced themselves and there were smiles on their faces and in less than a minute they were seen engaging in a lively chat. They seemed to have discovered a mutual ground; something common to share and to discuss. Their children were also seen playing together nearby.

In some cafés, there were some signs of disaggregation of participants but this was more of an exception than the common place. For example, in some communities, women were sitting only with other women. In Greenwich and Islington, women were sitting with other women from the same ethnic backgrounds. Picture 6.12 shows four women of the Islamic faith sitting together, and away from the other participants (the other women sitting at the table are WL note-takers).

Picture 6.12 – Interactions at a community café

At all cafés, participants demonstrated a high degree of interest in the discussions and were observed in deep engaging conversation. The interest and attention were particularly noticeable when somebody was talking and the other members were listening attentively without interrupting. Even when the participants disagreed, they demonstrated a high degree of understanding and mutual respect. Picture 6.13 shows a cross-section of participants.

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Facilitation was an important factor impacting participant engagement. There was one regular facilitator and the three others who stood in for her when she could not make the cafés. There were cafés, for example in Enfield, where the discussions did not go very well and the most obvious explanation was the facilitation. At the end of the event, the facilitator in Enfield was visibly frustrated because the discussions had not gone the way he wanted. However, the cafés which were facilitated by a trained and experienced facilitator such as the regular facilitator, particularly in Hackney, and Hammersmith and Fulham, were much more productive and enjoyable. In a few cases, the participants clapped to cheer and thank the facilitator.

The facilitator had to be flexible. For example, at the cafés where there were insufficient numbers of participants to form a table discussion, the facilitator arranged a whole group discussion or talked to them individually. An essential feature was to make people feel that what they were saying was important and that everyone had a chance to talk. This skill was particularly crucial when one or two participants monopolised the discussions. There were also instances when some participants came with their own agenda, and it was the facilitator's role to bring the discussions back to the original topic. Handling disagreements between participants was also crucial. At most events, the facilitators had to quell arguments skilfully without any party feeling slighted. The facilitator tried to make sure that everyone left the cafes feeling good about what they had contributed and heard. Observation of the community events showed the importance of the expertise of the facilitator and the

importance of this role to the success of the events and subsequent engagement of the participants.

Many residents were willing to complete the researcher's questionnaire. The response was particularly good when the facilitator mentioned the survey, such as in Ealing, Hackney and Westminster which recorded a good response rate. There were no refusals in Hackney. In Greenwich some participants completed the questionnaire with the help of their interpreters. Some participants did not feel comfortable providing socio-demographic data. In Ealing, a gentleman complained about the demographic questions being on the first page of the questionnaire. A female participant in the same area was rather aggressive about the personal demographic information. She was particularly unhappy to state the year and country of her birth, and how long she had lived in the UK. Surprisingly, despite her outburst in the beginning, she eagerly completed the questionnaire and even walked over to the researcher to hand it over.

Similar problems were experienced in Enfield where the respondents felt that the questions about age, date of birth and marital status were too personal. In most other areas, the participants were friendlier and there were barely any refusals. In fact, an elderly lady in Hackney who had not come with her reading glasses requested that the researcher read the consent form, questions and answer options to her.

The main reason among those who declined to participate across all areas, was rushing to work or pick up a child from school. In some areas, participants declined to participate if their partner had already completed a questionnaire such as in Southwark where a lady declined because her husband had already completed the questionnaire and she said they held similar views.

6.4. Community Action Workshops (CAW)

The CAWs involved community residents and local stakeholder organisations such as local authorities, NHS Trusts and voluntary sector organisations. The purpose of the workshops was to discuss the key problems raised at the cafés and to jointly find solutions appropriate for each area. The CAWs used an appreciative enquiry approach that brought together local stakeholders and

residents to jointly identify resources which could be mobilised to address the health and social needs highlighted during the cafés.

The researcher attended CAWs in Barking and Dagenham, Ealing, Hackney, Southwark and Westminster.

6.4.1. Facilities, Organisation and Attendance

The workshops took place in similar venues as the cafes and in many areas, the venues were the same. The workshops, however, did not have any exhibitions and the table set-up was different. Participants were seated around tables in groups of four to six. Refreshments were provided, and childcare was available at some of the workshops. Accessibility of the venues varied but most had wheelchair access.

The workshops in all areas took place in the morning, largely to be convenient for representatives of local stakeholder organisations who worked between 9am and 5pm and did not wish to change their working schedule. The workshops were meant to consist of equal numbers of residents and stakeholders. However, many workshops had very few local residents and this was very evident in Barking and Dagenham, and Southwark. Some stakeholders believed that the early timing arrangement caused the poor turnout of residents who in the mornings were either at work or in school. Other stakeholders believed the workshop schedule had nothing to do with the residents' attendance but rather that the residents did not anticipate that the workshop would be as entertaining as the café and therefore did not attend. Some also thought that the workshops had not been marketed as well as the cafes.

The residents who did attend the workshops were usually those actively involved in all community activities; these were the same people who attended all local meetings. An example from Barking and Dagenham below illustrates this:

In Barking and Dagenham, the local community was represented by three vocal participants – a female participant who had strong opinions on a number of local issues and who said she had lived in the area for many years; and two other residents who were also active in a number of local activities and who appeared to have good

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relationships with the local councillors and local authority staff. All three had a wealth of information about the local area and services.

Although it was not the norm in other areas, students from the local high school attended the workshop in Ealing and they contributed actively and engaged with the other participants.

6.4.2. Workshop Activities, Discussions and Facilitation

The activities at the workshops were meant to build on the café discussions by proposing possible solutions to the issues already identified at the cafes. However, at many workshops, the participants had not attended the preceding cafés and therefore were not in the position to follow up on the café conclusions.

Each workshop had an introduction which updated the participants on the 10 most important points brought up at the cafés. In most cases, this was followed by a long discussion of these points, and a number of participants disagreed with what was presented. Many participants involved in the workshop were new to the engagement process and wanted to express their views on the needs in their community rather than look for the solutions to the needs identified by someone else.

At many of the workshops, key discussion topics revolved around young people. At the CAW in Barking and Dagenham, residents were very passionate about issues concerning their youths as they felt that the youths had been portrayed as bad. They admitted that whilst some of the youths were into drugs "running" and other vices, not all the children and youths were bad. Most, they said, were in fact courteous, friendly and did not drink alcohol; most would even move off the pavement for an elderly person or a woman with a push-chair or children. However, they agreed that the children and youths needed something to do with their time and provision of sports facilities would be very welcome.

Facilitation at the workshops was of particular importance because of the nature of the appreciative enquiry approach which works against the grain of complaining or identifying what was wrong, and emphasizes what is good and what works in the community. The workshop included several interrelated parts

and it was important for the facilitator to give clear directions for each part of the process: a post card exercise, discovery, design and delivery, and a visual mapping exercise.

The quality of facilitation at the workshops varied. Those that did not have an experienced facilitator were seen to regress back to identifying issues and needs rather than finding solutions to the problems already identified. The facilitator was particularly good at the Ealing workshop which had a large group of 49 participants, some of whom were school children. The facilitator managed to conduct the workshop so that it was inclusive of everyone, as the observation below suggests:

The facilitator's task was to demonstrate how to look at things from different perspectives, points of view and mind-sets. She asked everyone to look around the room and to say what they could see. Participants said that they could see people, faces, emotions, tables. Then she requested that everyone stand on their chairs. This helped to lighten the mood in the room as people scrambled to get on their chairs. She then asked again what the participants saw now in the room. Some answers were: "the windows are dirty", "the skylight", "people smiling", "shoes". The facilitator then pointed out that one's view was dependent on where one stood, and one needed to change ones position to see things differently. The exercise was well received and set the tone for an interesting and constructive discussion.

In most areas, participants were enthusiastic to complete the survey, but it was evident that the response rate was influenced by the overall CAW atmosphere and the participants' satisfaction with the event. In Westminster, for example, where the workshop was very enjoyable and the researcher was introduced by the facilitator, the response was very good.

6.5. Project Implementation Meetings (PIM)

At the PIMs, the WL partners presented their programme plans outlining the projects tailored to the needs of each WL area to the residents and local stakeholders. This was the most formal of the three community events. The researcher attended and observed four PIMs in Barking and Dagenham, Ealing, Hackney and Southwark.

6.5.1. Facilities and Organisation of Meetings

The meetings took place at different times; some were in the morning, others in the late afternoon. The timing of the meetings did not appear to have any effect on the attendance or composition of the audience.

The venues were often the same as for the cafés and CAWs. However, in some areas, these were changed in response to the comments from the café and CAW attendees. For example, in Brent, café and CAW participants were unhappy that the engagement events took place outside their LSOA. Therefore the PIM was held at another location within the LSOA. Most of the venues were easily accessible but other facilities such as childcare and exhibitions were not present and refreshments were basic. Seats were generally arranged with chairs faced the same direction and there were no tables; it reflected a formal meeting where only one person could speak at any point in time.

6.5.2. Attendance and Participation

The majority of attendees were WL partners, local stakeholders and co-host organisations. The WL partners included those who were the borough leads and those who were responsible for the delivery of the specific projects. There were very few residents at these meeting. Those residents that did attend were the ones who were politically active, already engaged and had strong links with the local councillors or other community projects.

The dynamics of the discussions and interactions was very different from the cafés and CAWs. In some areas such as Barking and Dagenham, the meeting ended very quickly and appeared to be a rubber-stamping exercise with no discussions, interactions or networking. In other areas such as Ealing and Hackney, there were discussions between the participants, WL partners and other local stakeholders. Some appeared critical and antagonistic towards the programme. There were a number of occasions where participants were unhappy about the projects because they felt they did not reflect the needs of the community or that they were duplicating an existing service. A participant, who represented a local service delivery organisation in Hackney, commented that the activities were supposed to be delivered by local organisations but no one had approached the key community stakeholders. Local delivery organisations in all the areas attended expressed their disappointment when

they realised that their involvement in the programme would be marginal, contrary to what they had been led to believe. The meetings were facilitated by members of staff of the lead partner for each borough; therefore the mode and pace of the meetings varied considerably.

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Chapter 7 – Results:

Community Engagement Process and its Impact - The Communities' Perspective

7.1. Introduction

This chapter presents findings of the study from the perspective of the communities involved in the Well London (WL) programme. The community group are the residents who were involved in the community engagement events and who completed the questionnaire surveys and/or gave qualitative interviews. The data presented here is based on 134 questionnaires completed by café participants; 13 questionnaires by CAW participants who identified themselves as residents; and 12 qualitative interviews with local residents.

The chapter starts by presenting the characteristics of the residents who participated in this study, followed by the findings around the communities' views on the WL CEP and the impact as perceived by the community residents.

7.2. Socio-Demographic Characteristics, Health and Social Activities of Participants

This section describes demographic characteristics, health and lifestyles, social networks and perceptions of participants, and their current levels of community involvement.

7.2.1. Cafe Participants

A total of 134 residents completed the café survey in 14 WL boroughs: 59 in six phase-one boroughs and 75 in eight phase two boroughs. This constituted 21% of all the residents participating in the cafés in these areas.

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7.2.1.1. Socio-demographics

The mean and median age of the café survey participants was 41.5 and 44 years, respectively; the age range was between 13 and 88 years old. About three-quarters of respondents were female. Thirty-five per cent of respondents were married or lived with a partner; about a quarter were either divorced or separated; 30% were single and nine per cent widowed (table 7.1).

The highest proportion of respondents had a secondary school qualification (44%); 37% had a higher education degree; and one in ten reported a primary school education only. A third of respondents (34%) were employed either full-time or part-time; about seven per cent were in self-employment; 15% were retired from paid employment; 11% were unemployed; 10% were students; and eight per cent were unable to work due to illness or disability (table 7.1).

Over half of the respondents (56%) were born in the UK; 12% in other European countries (Belgium, Cyprus, France, Germany, Ireland, Italy, Poland, Portugal and Turkey); 13% in Africa (Ethiopia, Gambia, Kenya, Liberia, Nigeria, Sierra Leone, Somalia, Sudan and Zimbabwe); 6.2% in the Caribbean (Jamaica, Montserrat, Trinidad and West Indies); 5.4% in South and South-East Asia (Afghanistan, Bangladesh, India, Pakistan and Vietnam); 3.1% in the Middle East (Iraq, Israel, Kuwait, Palestine); 2.3% in North and South America (Argentina, Canada and USA); and 1.6% in Australasia (New Zealand). The length of stay in the UK for those born outside the country ranged from three months to 51 years. Over 60% of respondents reported English as their first or preferred language. Other main languages included Spanish, Arabic, Chinese, German, French, Turkish, Hebrew, Polish, Gujarati, Punjabi and Somali.

White British and Other White were the dominant ethnicities, together accounting for over half of the respondents (58%). The highest proportion of non-White respondents were Black (African, British and Caribbean) accounting for 25% of respondents. The remaining respondents reported being Asian (7.7%), and 12% were Mixed and Other ethnicities.

The majority of respondents (48%) were Christians; Islam was the second most common religion reported by 19% of respondents. About a quarter of

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respondents (26%) said they did not practice any religion; 6.6% said they were Alevi, Buddhist, Greek Orthodox, Hindu and Jewish.

The length of stay in the neighbourhood ranged from three months to 70 years; and the mean length of stay was 16.7 years; a quarter had stayed in their neighbourhood no more than five years.

Table 7.1 shows socio-demographic characteristics of the café respondents.

Socio-demographic characteristics	Frequency	Per cent
Age Range (years)	n=120	
<16	4	3.3
16-24	12	10
25-34	20	17
35-44	37	31
45-54	13	11
55-64	18	15
65 and older	16	13
Mean age=41.5 years; Age range= 13-88years Median age=44 years; Standard deviation=18.90974		
Gender	n=132	
Female	100	76
Male	32	24
Place of Birth	n=129	
UK	72	56
Other Europe	16	12
Africa	17	13
Middle East	4	3.1
South and South East Asia	7	5.4
North and South America	3	2.3
Caribbean/West Indies	8	6.2
Australasia	2	1.6
Employment Status	n=134	
Employed (full/part time)	45	34
Self employed	9	6.7
Retired	20	15
Looking after home	9	6.7
Unemployed	15	11
Unable to work (illness/disability)	11	8.2
Students	14	10
Other	3	2.2
Prefer not to say	8	6.0
Educational Attainment	n=134	
Higher education	50	37
Secondary education	59	44
Primary education	13	9.7
Other qualification	3	2.2
Prefer not to say	9	6.7
Ethnicity	n=130	
White British	55	42
White Other	16	12
Black and Caribbean	33	25
Asian	10	7.7
Mixed and Other	16	12
Marital Status	n=134	
Married/Cohabit	47	35
Divorced	19	14
Separated	12	9.0
Single, never married	40	30
Widowed	12	9.0
Prefer not to say	4	3.0
Religion	n=121	
Christianity	58	48
Islam	23	19
No religion	32	26
Others	8	6.6

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Socio-demographic characteristics	Café Surveys % n=134	WL Survey % n=4035	Statistical Testing
Age Range (years)			
16-24	12	21	chi² (6df) = 148.78
25-34	15	28	p = 0.0012
35-44	26	23	
45-54	9.7	12	Test for trend (1df) = 10.46
55-64	13	7.3	p = 0.0000
65 and older	12	9.2	
No response	12	0.0	
Gender			
Female	75	57	chi² (1df) =22.2772
Male	24	43	p = 0.0000
Employment Status			
Employed	40	44	chi² (6df) = 11.2243
FT Education	10	13	
Unemployed	11	20	p = 0.082
Retired	15	9.3	
Home-maker	6.7	5.6	
Not working (illness/disability)	8.2	5.9	
Other	2.2	2.0	
Educational Attainment			
Primary	10	12	chi² (4df) = 29.2746
Secondary	44.	59	
Higher	37	28	p = 0.0000
Other	2.2	0.8	
Marital Status			
Single	30	45	chi² (4df) = 42.8171
Married/Co-habiting	35	41	
Separated	9.0	3.2	p = 0.0000
Divorced	14	6.4	
Widowed	9.0	4.6	
Religion			
Christianity	48	51	chi² (3df) = 1.7754
Islam	19	18	
No religion/Other	33	30	p = 0.620
Ethnicity			
White British	41	34	chi² (4df) = 7.9096
White Other	12	13	
Black and Caribbean	24	27	p = 0.095
Asian	4.5	14	
Mixed and Other	16	14	
Not reported	3.0	0.0	
Place of Birth			
UK	54	50	chi² (1df) = 0.4217
Outside UK	43	50	
Not reported	3.7	0.0	p = 0.516
Length of Stay in UK (non-UK born)			Mann-Whitney U test p = 0.0085
Observations	58	2182	
Mean (years)	22.5	13.9	
Range (years)	0.25 – 51.0	0.08 – 84.0	
Length of Stay in Neighbourhood (all)			chi² (4df) = 36.92 p = 0.0000
Mean (years)	16.7	8.9	
Range (years)	0.25 – 70.0	0.08 – 91.0	Test for trend (1df) = 28.51 p = 0.0000

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Table 7.2 above shows the comparison of the study participants' with the socio-demographic characteristics of residents in WL areas through the baseline WL survey conducted in 2008, which was a probability sample of over 4000 respondents.

7.2.1.2. Health and Healthy Lifestyle Intentions

Almost half (46%) of the cafe participants described their health as 'good' or 'very good'; 30% said they had 'fairly good' health; and 17% said their health was 'not good', 'bad' or 'very bad'. Of all the respondents, 39% reported that they had been diagnosed with one or more long term illnesses. About 14% reported smoking daily and seven per cent reported drinking alcohol daily.

In terms of general wellbeing, 73% said that they were either 'very happy' or 'quite happy'; and about one in five respondents were 'not very happy' or 'not at all happy'.

In table 7.3, the data from this study is compared with available data from both the WL baseline survey and the national General Lifestyle Survey (GLF) 2009 (Ali & Dunstan, 2011). The comparisons suggest some variations and differences in self-assessed health and happiness; as well as reported long-term illnesses or disability, smoking and alcohol consumption among the café participants and both the WL and GLF survey participants.

	Café % n=134	Well London % n=4056	GLF 2009 % n=25000
Happiness			n/a
Very happy	15	23	
Quite happy	58	63	
Not very happy/not at all happy	22	14	
Test for homogeneity chi² (2df) = 4.10 p > chi² = 0.1286 Test for trend chi² (1df) = 1.75 p = 0.1858			n/a
Reported health		n/a	
Very good/good	46		79
Fairly good	30		15
Bad/very bad	17		6
chi² (2df) = 69.37 Test for trend chi² (1df) = 68.10 p = 0.0000			
Long-term illness	39	n/a	30
Daily smoking	14	n/a	21
Daily alcohol	7	n/a	23 (men) 12 (women)

Café respondents mostly believed that they had a lot of influence over their own health by choosing the way they lived; they said general healthier habits like giving up smoking, drinking less alcohol, losing weight, increasing level of physical activity and reducing the level of stress would make their lives healthier. One in four respondents had tried making one or more of these changes in the last 12 months. Only four per cent thought people had no influence at all over their own health.

There appeared to be a good level of general awareness of activities which could improve their health; 71%, 64% and 43% of respondents listed activities which could improve physical activity, healthy eating and mental health, respectively. Also respondents said leading a less stressful life, calming down, socialising more with community, communicating and making new friends, and being more confident and happy would improve health.

7.2.1.3. Social Networks, Perception of Neighbourhoods, and Community Involvement

A majority cited family members, professionals, friends and faith groups as people and places they would go to for help. Very few respondents (10%)

reported that they would go to a neighbour or other people in the community. Over one on ten respondents said that they would cope on their own.

The General Household Survey (GHS) 2000 is the most recent national survey which included a Social Capital Module. It found that over half of respondents (58%) had at least five people they could turn to in times of crises; and only 2% of said they had no one (Coulthard et al., 2002). The WL baseline survey also asked respondents the number of people they could go to in a time of crisis; and this is presented as a comparison of this study in table 7.4 below.

Table 7.4 – Number of people respondents could go to in a crisis

	% respondents (café)	% respondents (WL)
Number of people respondents could go to in a crisis	n=134	n=1945
3 or more	21	37
One or two	65	41
No one/will cope on my own	13	22
	chi² (2df) = 29.42 Test for trend chi² (1df) = 0.64 P = 0.4241	

About 40% of respondents felt 'very safe' or 'fairly safe' in their neighbourhoods even after dark, while 33% felt 'a bit unsafe', and 11% felt 'very unsafe'. One in ten respondents in this survey were 'never out alone when dark' (Table 7.5). The comparison with the GHS survey show that the café participants felt more unsafe than the GHS sample (44% compared to 26%) although the proportion of those who never go out alone after dark was lower (10% compared to 20%) (Table 7.6)

This survey found that the respondents' length of stay in their neighbourhood was similar to those of GHS. In this study, 25% had lived in their neighbourhood for less than five years, similar to GHS respondents (22%). Those who had lived 6 to 20 years in this survey were 33% while the GHS was 35% (Coulthard et al., 2002) (Table 7.6).

Only 43% of respondents in this study were 'very satisfied' or 'satisfied' with their neighbourhood; which is much lower than the GHS sample (87%). A quarter of café respondents were 'very dissatisfied' compared to 16% in the WL survey (Table 7.6).

Table 7.5 – Length of stay, perceived safety and satisfaction with neighbourhood (café)

	Frequency	Per cent %
Length of stay in neighbourhood (years)	n=75	
0 – 5		
6 – 10	19	25
11 -20	12	16
21 -30	13	17
31 +	12	16
No answer	9	12
*Information provided here is from only the second community cafe questionnaire survey as the question was not asked in the first survey conducted. Therefore, n=75.	10	13
Perceived safety in neighbourhood (when dark) (n=134)	n=134	
Very safe	24	18
Fairly safe	29	22
A bit unsafe	44	33
Very unsafe	15	11
Never out alone when dark	13	9.7
No answer	9	6.7
Overall satisfaction with neighbourhood (n=134)	n=134	
Very satisfied & satisfied	58	43
Neither satisfied nor dissatisfied	22	16
Very dissatisfied	32	24
No opinion/no answer	22	16

Table 7.6 – Comparison of length of stay in neighbourhood, overall satisfaction with neighbourhood and perceived safety (café, Well London, GHS 2000)

	Café % n=134	Well London % n=4056	GHS 2000 % n=20000
Length of stay (years)			
0 – 5	25	49	22
6 – 20	33	41	35
20+	21	10	43
	chi² (2df) = 36.92 p = 0.0002 Test for trend (1df) = 28.51 p = 0.0000		
Overall satisfaction			
Very satisfied & satisfied	43	63	87
Neither satisfied nor dissatisfied	16	20	not
Very dissatisfied	24	15	available
No opinion	16	1.4	
	chi² (2df) = 7.09 p = 0.0288 Test for trend (1df) = 5.21 p = 0.0224		n/a
Perceived safety			
Very safe	18	7.5	21
Fairly safe	22	39	34
A bit unsafe/ very unsafe	44	40	26
Never out alone when dark	10	13	20
	chi² (4df) = 22.60 p = 0.0002 Test for trend (1df) = 4.59 p = 0.0321		n/a

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In this survey, 35.8% of respondents had participated in two or more community activities in the past 12 months; 32.8% had participated in only one activity; and 26.1% had not participated in any community activity. These activities included signing petitions, attending public meetings or rallies, taking part in a public demonstrations or protests, completing a questionnaire and being involved in a local area group set up to discuss local services or problems. This data could be compared with the national data only, as no such question was asked in the WL baseline survey. The rates of participation compared favourably with the GHS data where 66% of respondents had been in local organisations (Coulthard et al., 2002).

7.2.2. CAW Resident Participants

Thirteen of the 63 CAW survey participants identified themselves as residents; nine were female and four male. The average length of stay in the neighbourhood was 20.5 years, ranging from one year to 54 years. English was the first or preferred language for 11 of these 13 respondents. Three respondents reported having a disability or long-term illness which affected their daily activities.

Only one of the respondents had attended the café event which preceded the workshop. However, 10 respondents said that they were 'very likely' or 'likely' to attend future community events.

7.2.3. Qualitative Interview Participants

The respondents that were interviewed included 12 community residents aged between 27 and 88 years. These were eight women and four men living in the target communities. Three respondents were employed; one was self-employed; four were retired from paid employment; three were taking care of their home, and one was a student.

7.3. Perceptions of the WL CEP

The residents' perception of the WL CEP presented in this section was examined through the community cafe surveys, the CAW survey and the qualitative interviews.

The majority of café participants reported no barriers to attending the event; the few (5.2%) who experienced some form of barrier had managed to overcome the barrier and had attended the café. Half of the respondents said that the café had met their expectations 'completely' or 'a lot'; one in three said their expectations had been met 'fairly'; and only 2.2% said the café had not met their expectations at all. Three in four respondents believed that some or all of their concerns and views had been heard during the event. Four in five respondents said that they were 'very likely' or 'likely' to participate in similar community activities in the future (Table 7.7). Similarly, 10 CAW resident participants (77%) said that they were 'very likely' or 'likely' to attend future community events. No comprehensive data could be collected on this issue.

Table 7.7 – Café respondents' experience of the WL community café: barriers, expectations and likelihood of participation in similar events

Barriers, expectations and likelihood of future participation	Frequency n=134	Percent %
Did you experience any barriers coming for the café?		
Yes	7	5.2
No	102	76
Prefer not to say	25	19
Were your expectations of the café met?		
Yes, completely	34	25
A lot	33	25
Fairly	46	34
Not at all	3	2.2
Prefer not to say	18	13
Do you think your concerns have been heard?		
Yes, completely	62	46
Fairly	38	28
No, not at all	3	2.2
Don't know	15	11
Prefer not to say	16	12
How likely are you to participate in similar events in the future?		
Very likely	75	56
Likely	34	25
Unlikely	2	1.5
Don't know	4	3.0
Prefer not to say	19	14

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The CAW respondents said that they felt their concerns had been heard completely (45%) or fairly (32%); 11% of the respondents said they did not know and one respondent said "not at all". A fifth of the respondents said that the workshop met their expectations 'completely'; half said it met their expectations 'a lot'; and about a third said it met their expectations 'fairly'. Although there was an option of 'not at all', none of the respondents chose this option.

7.3.1. What was good about the CEP?

Based on the surveys and qualitative interviews, ten positive aspects were identified; and these can be subdivided into two groups: the key benefits of CEP as perceived by the residents; and the factors which made the engagement events affective (Figure 7.1).

Figure 7.1 – What was good about the CEP?

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What was good about the CEP?

Key benefits of CEP:

➢ Provided opportunity for socializing and meeting people
➢ Provided opportunity to talk about needs and share ideas
➢ Provided information about activities and projects
➢ Brought together a diverse range of participants
➢ Relaxing and friendly atmosphere of the cafe

Factors that made events effective:

➢ Friendly and helpful staff
➢ Good food and drinks
➢ Experienced facilitator
➢ Informative exhibition and blackboard
➢ Interactive appreciative enquiry process

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A large number of survey respondents felt that opportunities for discussions and sharing views, ideas and opinions were key positive features of the cafés; many said that the cafés were good for socialising and meeting people. Many liked the atmosphere of the cafes and noted the positive impacts of refreshments and crèche facilities. The respondents noted that the atmosphere of the cafés was good in terms of the physical ambience and the people who were there. Thus, one café participant commented:

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- *"The community café was fun because it was bright and colourful."*

Another resident noted how the café had transformed the usual gloomy atmosphere of the local community centre:

- *"They transformed the space and the hall is more welcoming than it usually is".*

Overall, many respondents thought that the exhibition was helpful, informative and useful; and it gave a *"whole view about the project"*. The exhibition seemed to be a good way of brightening the environment as well as providing information about the projects. Community members could take information at their own pace; they also had a chance of giving feedback and asking questions. All the respondents who answered this question complimented the exhibition. The café participants also liked the blackboard which was provided for participants to leave their comments and opinions. They thought it was a good tool to get people involved.

The positive comments made by residents about the CAWs were about the process and people involved in the workshop. Many noted the diversity and range of participants, which allowed for networking and sharing ideas. They were particularly happy with the appreciative enquiry process which they felt promoted an integrated working environment. The participants were also pleased with the level of engagement, the structure of the sessions and the skills of the facilitator. They believed that the facilitator was effective and inspiring, and was the key to the engagement of participants.

Among in-depth interview participants, a number of interviewees found the events useful and interesting; they appreciated the opportunity for people of various backgrounds to come together and talk about their mutual needs. Participants observed that everyone had an opportunity to have their say and be listened to at the community cafes, as one participant explained:

"...like the cafe, it got us all together and it got us talking about what we needed."

(CTE- F/34/Housewife)

Another participant noted the number and diversity of people at the cafés, and commented on how everyone was given an opportunity to express their views and to hear about the views of others:

"What I found interesting by coming...is to realise that many people wanted to participate and many kinds of people from many different backgrounds and different social level; and everybody had something to say, and everybody could talk and everybody else listened to the other ones." (SVE- F/44/Dietician, Homemaker and Carer)

Another important aspect identified by qualitative interview participants was socializing, which was thought to be the key component of the process. The interviewees noted again and again that the community café allowed the residents to interact with one another and get closer.

"...that was an opportunity to at least get close and engage with people in the neighbourhood." (CGE- M/58/Self-employed artist)

7.3.2. What could be improved?

The participants were also asked what they felt could have been done better in the community events. Here, the participants talked about substantive issues of the engagement content and process; and organisational aspects of the events (Figure 7.2).

Figure 7.2 - What could be improved?

What could be improved?

Substantive issues:

➢ Better justification of the area selection
➢ Focus on the people living in the target areas
➢ Engaging more young people and making the events more relevant to them
➢ Engagement of the hard-to-reach groups in the community
➢ Clearer information about the programme, its content, funding and focus
➢ Better focus on the community and the people rather than just health and illness
➢ A need for being more responsive to the community concerns even where they are outside the scope of the programme
➢ A need for more realistic and sufficient timescales for what is planned
➢ A need for follow-up and feedback after the CEP

Organisational aspects:

➢ Better timing of the events to allow more residents to attend
➢ More time for discussions in each section of the programme, particularly at CAWs
➢ Opportunities for physical activities and exercises at the cafés
➢ Better publicity for the events
➢ More accurate information about the areas and its residents
➢ Better acoustics of the venue
➢ Better food options

About a third of the survey participants said they didn't think anything could be improved in the cafés. Those who thought there was room for improvement commented on the number and types of participants involved. A number of respondents, for example, said they would like to see more local people at the events, the actual residents of the target areas, as they observed that many people who attended the events were not always from the target neighbourhoods. Several participants suggested engaging more young people by having more activities for children and teenagers; for example, more rhythm

and blues (R&B) and hip-hop music played at the cafés. Another group which did not seem to be represented at the events was the so-called hard-to-reach members of the community. Some respondents commented that engagement of these groups could provide an entry to their community and their involvement in the programme activities.

Reflecting on the café questions and discussions, some respondents said that the events were too focused on health and illness rather than on the community and its people. They suggested that the themes had to be broader and more inclusive; for example, one participant wrote in his comments:

- *"We're people – not illnesses and problems".*

Some respondents felt that more publicity for the events would achieve better attendance rates and a better focus on the target populations.

At some cafes, there were complaints about the acoustics of the hall and the quality of the microphones, and a number of participants could not hear the speakers properly, which had an effect on their ability to engage in the discussions. Some respondents suggested having more engaging facilities; for example, space for exercise, fitness and food demonstration sessions. A few respondents said that the food could be improved but the opinions on what exactly to improve varied. Some respondents recommended having more vegetarian food options while others said that for them, the *"food was a bit too healthy".*

The key issue named by several CAW participants was timing of both the actual workshop and the different sessions within the workshop programme. They felt that the workshops which were scheduled for weekday mornings were not suitable for the residents who had other commitments like employment, taking children to school, or going to collect benefit money from the post office. In terms of the logistics of the workshop sessions, the respondents said that some of the sessions were too short while others were too lengthy. For example, they wanted more time for feedback, networking and rounding up at the end. On the other hand, they felt that some sessions like the introduction and feedback from the café at the beginning of the workshops were too long and tedious,

and had little opportunity for discussion. The comments about the timing of the sessions were common across several boroughs.

Qualitative interviews provided more insights into the feelings of the café participants and helped to better understand the reasons behind the comments made during the survey. Thus, some negative emotions expressed by the events participants turned out to be due to the poor knowledge of the WL programme and how it worked. For example, a number of residents did not know where the money for the projects was coming from; many assumed that the WL programme was funded by the local authorities and in their views it was not an effective way of spending council resources. They felt that the money could be better used for housing repairs and other more visible projects in the area:

> *"A lot of the residents… when all this money is being spent, they think it's all just coming from the council…But when you try and tell them that it's out of a different pot, they still say, 'why can't we have that done?'" (INS- F/70/Retired)*

This view was present in several areas where people complained about such issues as dampness and overcrowding. For them, these were more important health priorities than diet or exercise, and they wanted the money from the programme to be used to address these problems.

In some areas, the residents' perception of the CEP was influenced by other things happening in their area at the same time, and they used the CEP to express their dissatisfaction about these changes. However, when they realised that the programme was not in a position to do anything about these specific issues, the residents became frustrated and turned their anger against WL. For example, in Barking and Dagenham, the local authorities planned the demolition of a local community hall. Café participants expressed serious concerns about this decision and made it clear that they wanted to keep the hall as an essential facility contributing to their wellbeing. Yet, the community hall was demolished shortly after the cafés. The residents interviewed in this area felt angry and frustrated, not only because their community hall had been demolished, but also because WL was unable to address their needs expressed during the community consultations, as one interview participant illustrated:

"...the point of the exercise... what we went there for, seems to be not really listened to...because all the council have done is the opposite of what the people have said. Instead of providing facilities, they are now taking facilities away". (MRB- M/27/Recycling Collector)

In some areas, people were both surprised and upset to see which areas were selected as the target areas. These feelings were expressed both during the surveys and in-depth interviews. In one borough, for example, the WL area included partly an industrial estate and partly a regeneration area where no one technically lived, as one resident explained:

- *"Most of this area is industrial and over 50% of the SOA will be of no use to you because they are industries and golf courses, not residences. Meanwhile the areas that are residences are being regenerated, and you will be left with almost no one in the area."*

Interview participants further explained how frustrated people were to see the inability of the programme to recognise essential variations between communities selected. It was argued that the WL areas were similar only in their IMD scores; they differed in their past and present experiences of community engagement, regeneration, relationships with local and external organisations, and in the composition of the people in the community. Therefore one single process could not be used satisfactorily in all these different areas. The interviewees argued that the programme should have spent more time studying the selected locations, their specificities, cultures and politically and socially sensitive matters such as reallocation of local residents due to regeneration:

"They [Well London] should have done more research about the area before they embarked on the project and understood the extreme sensitivity of the people who are being moved around the area or moved out of the area." (JGE-M/60/Local Councillor)

Some participants felt that the choice of the areas was too artificial and narrow, and that many deprived estates had been unfairly excluded from the programme. They said that participation could be improved by including all residents because the process made some residents feel left out and affected their involvement in the consultation process. A respondent in Southwark did

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not approve of the way the LSOA for the interventions was singled out, as many surrounding areas were left out:

"...they only chose the Cossall Estate and we were left out...so...we haven't seen any of the benefits here... yet." (JQS- F/61/Retired)

Another issue raised at the cafés and interviews was inaccuracy of the names of the local areas, which was also perceived as a lack of local knowledge. Participants in one area, for example, explained that the cafe invitation posters called their area *"Oak Tree Neighbourhood"*. However, there was no such thing in the area; there was the Oak Tree Community Centre. The residents referred to their neighbourhood as the South Acton estate and wanted the external organisations to respect that. Qualitative interview participants further explained that the residents felt that the WL organisations did not adequately understand them and the issues they were dealing with. Therefore, a simple mistake such as a misprint of the name of the area was perceived as an attack on the local sovereignty and decision-making:

"They decided on a name which was like 'Bollo Bridge Area' or something, which was rejected by the people who live there, who call it South Acton Estate, and don't want any changes to the name." (JGE- M/60/Local Councillor)

In terms of the type, quality and quantity of information given to the community before and during the consultation process, the respondents said that they thought the information was good but at times too much to take in at once; there was information about not only the CEP itself which was a new initiative, but also health promotion and delivery, and community organisations and their activities. Many information materials used new terminologies and acronyms which were difficult to understand. The respondents said that they would need some more time to be able to absorb the information they had received:

"I mean it's good... but it's like overload, information overload." (CGE- M/58/Self-employed artist)

There was also a feeling that the programme tried to do too much within a short and limited space of time and resources:

"It's too broad and wide, you know, it's an "all things, all man" sort of thing; so where do you get on board?" (CGE- M/58/Self-employed artist)

A number of participants wanted some form of feedback and follow-up so that the process would not be a repetition of past consultations where they received no feedback after they had given their time and efforts; in the past they had found this very disheartening and discouraging:

"I think generally we need some follow-through." *(CTE- F/34/Housewife)*

7.4. Incentives and Barriers to Participation

The research also looked at what motivated or incentivised people to take part in the consultation process and what were the barriers to engagement.

7.4.1 Incentives and Facilitators of Community Engagement

This section looks at two groups of factors: 1) those that encouraged people to take part in the community consultation events; and 2) those that made their participation easier.

Incentives or motivators in this study are examined through the reasons why people engaged in the cafés and CAWs, what their expectations were, or what they thought they may derive from the community engagement process. Facilitators refer to the factors which helped or supported community members' participation. This study identified 11 factors that acted as incentives or motivators and five factors that facilitated the process of participation (Figure 7.3).

Figure 7.3 – Incentives and facilitators of participation

Incentives

- ➢ A wish to develop a better community to live in
- ➢ A wish to get to know neighbours
- ➢ A wish to voice concerns and make needs known
- ➢ A wish to play a part in the community
- ➢ A wish to have fun with the family
- ➢ A wish to socialise and network
- ➢ A wish to share ideas
- ➢ Specific interest in the consultation themes, and/or a wish to know more about them
- ➢ Being a part and a representative of the community
- ➢ Curiosity
- ➢ Opportunistic participation

Facilitators

- ➢ Provision of information about the events
- ➢ Provision of refreshments
- ➢ Availability of crèche facilities
- ➢ Wheel chair access
- ➢ Language translators

7.4.1.1. Incentives

The key reason for attending the cafés was a desire to have a say in the decisions that affected local communities. Many participants believed that the consultations were important because the projects were supposed to affect communal properties in the neighbourhood, and the residents wanted to have a say in how they viewed them. Many residents also took part in the cafés because they had a desire to change their communities for the better and they felt that joint actions would have a greater impact on the change. Many people wanted to change their environments. They said that if communal areas were available and the neighbourhood felt safe, people would be more willing to come out and socialise.

Sharing ideas was also a prominent reason for attending the cafes. The residents felt that the cafés were good forums to have their opinions aired with the confidence that these opinions would be heard and acted upon. Many respondents wished to contribute to the debates on the local issues because they believed they were best placed to decide what the priorities were and

what to do about them. This is how the respondents described this set of reasons for attending:

- *"if money is being spent, I want to share my ideas, meet local residents and hear other people's ideas"*
- *"...I think it is the place where I can say my opinion fairly and there is someone who will hear and interact with me"*

Some respondents had specific interests in the themes discussed at the cafés such as healthy eating, physical exercise, mental wellbeing, open spaces and arts and culture. Many respondents were particularly interested in mental wellbeing and community cohesion.

A number of respondents said that they wanted to get information about the WL programme, local services or health promotion in general. Some participants wanted to know about all themes discussed; others were interested in a particular topic, which was their main priority or concern, and they focused on that:

"Education in the community through art; that's what works for me... it's got to be specific because I really haven't got the time for taking on board a lot of the other themes." (CGE- M/58/Self-employed artist)

Some respondents wanted to network, socialise and meet other people. There was an expectation that the event would be fun for the whole family because of the clowns and the balloons at most of the venues. A number of respondents said that there was little to do as a family in the area; many events were costly. Therefore, they welcomed an opportunity to come to a friendly entertaining event which was free.

A few of the respondents came to the cafe as part of their work, for instance the local councillors. Others came because they were the residents of the area and the events were organised for them.

A number of participants attended because they wanted to be a part of the community, especially if they were not originally from that neighbourhood, and they felt that by attending they could meet people from many different backgrounds and to see what they have in common.

> *"...there are so many people from different countries and I'm sure they will feel they have a place in London if they can be a part of this community." (SVE-F/44/Dietician, Homemaker and Carer)*

A few respondents did not have any particular reason for attending. They participated out of curiosity; they heard about the event and decided to come to see what it was like. Some attended opportunistically because they happened to be around the venue and were invited to come in by the organisers:

> *"We attended by chance because to be honest, we hadn't seen it advertised...we (were) passing that day and we saw the clown with the balloons and the kids wanted to go and see what was going on" (CCB- F/30/Housewife)*

7.4.1.2. Community-Belonging as an Incentive for Participation

As being part of the community was an important motivator for a large number of participants, the researcher looked specifically at what the term "community" meant for the people. The semantic analysis of the qualitative interviews showed that the word 'community' was the most frequent word used in the participants' narratives. Belonging to the community was a key incentive for participation in the consultations; and this belonging was expressed largely through two attributes: location and relationships. The residents described their community in terms of place, helping one another, having compassion about similar issues, working together, friendliness, getting along, building and having mutual trust and equity.

For some people, community was the physical relationship of a group who shared the same location or physical space:

> *"It means the mass of the people who live on the South Acton Estate." (JGE-M/60/Local Councillor)*

For others, it was social relationships and networks within the local community:

> *"...[community means] everyone [who] lives in a specific area getting on...pitching in and helping." (CCB- F/30/Housewife)*

Many respondents described community through feelings of mutual helpfulness and compassion, irrespective of age, gender, culture or creed; the friendliness that comes from knowing a person and being able to chat with that person about simple things like the weather or more complex issues that affect the community, and being able to get along and work together for the good of the community, as one participant noted:

> *"…[community] means socialising, meeting and trying to help each other…there is a lot we can do to look after each other in the community; … if someone is out of their house, just watching their house." (CTE- F/34/Housewife)*

Equity was an important part of the respondents' feelings about community; they talked about equity and tolerance in different domains: cultural, racial, religious, age, gender and socio-economic. They wanted to see good interactions between varieties of people. Some respondents believed that in a multicultural society like the UK, a community can only truly exist when all ethnic, cultural and religious differences are put aside and people live peaceably and happily together irrespective of their differences:

> *"The community means it doesn't matter what culture, what creed or what colour you are; once you all (are) happy and you all get on. That's what community means to me". (JAH- F/58/Dinnerlady)*

Some respondents equated the relationships in a community to those that exist within a family; where trust exists. These participants argued that the better the relationships in the community are, the easier and more meaningful the lives of its members will be. This in turn makes it easier to relate and participate in the activities that go on in the community. A number of respondents emphasised the need to work together towards collective goals which can make the community better, as everyone in the community share similar experiences and needs, and use the same open, green and social spaces.

> *"A community is basically where everyone works together. Everyone works together for the better; not for any individual cause, but for the overall cause for everyone." (MRB- M/27/Recycling Collector)*

7.4.1.3. Facilitators

There were a number of factors which assisted participants' involvement in the community events. First, Information about the events appeared to play an important role in community engagement. About one in three café respondents indicated that they had found out about the event from the leaflets posted through their doors or posters put up at various venues in the community. One in five respondents found out through the local community organisations or associations. One respondent saw a poster on a local bus; another said they had been alerted by a message on their mobile phone, another found out from their place of work. One in ten respondents heard about the events from their friends or neighbours. A few more were involved in the planning of the event or knew the event organisers. Almost one in five did not know about the event until the day; these participants were invited by the organisers while being out in the street.

Respondents were also asked how they normally access information about community activities. The responses to this question varied widely. About half of the respondents received information through local organisations. Publicity materials like leaflets and posters provided information for almost a third of the respondents. About a fifth received information from local newspapers, newsletters and magazines. Some obtained information through family, relatives, friends and neighbours; others received information from the internet through e-bulletins and websites.

Other facilitators named by the participants included crèches, refreshments, wheelchair access, and opportunities for translation. Parents who brought their children along said that the crèches helped them to relax and fully participate in the event, as one mother explained:

> *"My daughter was with me that day; and to do something with an autistic child is very difficult...I realise that there was...a babysitter to take care of the children; that's very nice." (SVE- F/44/Dietician, Homemaker and Carer)*

Another mother said that the cafés were very engaging and interesting for both adults and children:

"My daughter came with me as well. She really enjoyed it. She was seven at the time, she's eight now. She just liked being in that environment, sitting there and talking. She actually came and spoke as well for a bit…" (LWB- F/31/Student and Mother of three children)

Free food and drinks was an incentive to some but not all participants. Although a number of residents said that an opportunity for a free meal was a motivator, for many participants, sharing ideas and having their opinions heard was much more important than the refreshments. Some participants noted that the venues were accessible for wheelchair users and residents with limited mobility, and this helped facilitate their participation. Some also noted the presence of interpreters at the events. They believed that this facilitator helped many residents who did not speak English very well, engage in the discussions and activities.

7.4.2. Barriers to Participation and Ways to Overcome Them

Academic literature suggests that although community events are generally supported, many people are not able or willing to contribute to the CEP as they experience barriers which prevent or limit their involvement in the community life. As this study did not involve those who could not come to the community events, the barriers presented here are either those that the residents experienced but managed to overcome, or those reported by the participants on behalf of non-participants. This study identified physical; institutional or political; personal; and collective barriers to participation (Figure 7.4).

Figure 7.4 – Barriers to Participation

Barriers	Issues identified
Physical	➢ Safety concerns ➢ Inaccessible venue ➢ Area regeneration ➢ Timing of events ➢ Unclear messages and information about event
Institutional	➢ Conflicting or competing organisational priorities ➢ Perceived lack of community understanding ➢ Regulations and legislations
Political	➢ Unresolved local tensions ➢ Antagonism towards local authority
Personal	➢ Physical health and wellbeing ➢ Childcare and family care commitments ➢ Shyness or lack of social skills ➢ Lack of time ➢ Lack of interest ➢ Language barriers ➢ Socio-economic circumstances
Collective	➢ Feelings of distrust towards external agencies ➢ Misperceptions of programme intentions ➢ Distrust of external agencies ➢ Consultation fatigue and apathy ➢ Lack of information

The perceived lack of safety was one of the most important barriers reported by café participants, particularly those who came for the evening café. Many people were afraid of going out when it was dark or when they were alone. This was especially true for older people but not exclusive to them. At the café in Haringey, a resident said that he lived 250 yards away from the café venue but had to drive because it was dark and he didn't feel safe walking.

Physical health was also an important issue. This barrier was reported in several areas especially where people said they had long-term illnesses or disabilities. In Southwark for example, one participant said that she was not feeling very active that day and just wanted to lie down although she eventually decided to attend the café. For this respondent, the free food provided at the event appeared to be an important incentive for participation. In her questionnaire she explained that *"the thought of free food"* helped her to overcome the fatigue and encouraged her to attend the consultation.

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Another barrier identified in the café survey was time. This barrier was consistently reported at all the cafes and CAWs. Many respondents were time-poor due to long working hours and other commitments. A respondent in Ealing said he had a very busy day and *"had to rush"* to be able to attend the cafe. There were also suggestions that the community engagement required too much personal time from participants. In-depth interview participants also noted the issue of timing, as timing of most engagement events conflicted with the residents' work schedules and prevented them from participating.

Childcare was another problem by the café participants. Although crèche facilities and play areas were provided at most cafés, not everyone knew they would be available. People hesitated to bring their children with them and were unwilling to leave them at home or pay for childcare. Many respondents said they were pleasantly surprised to see the crèche facilities provided at the cafés.

Some respondents reportedly decided not to come because of the antagonism between them and the local authorities. This antagonism was reflected in their attitudes towards the programme because many viewed the WL programme as an extension of the loathed local authority and its agencies, and they did not want to have anything to do with it. In Ealing for example, there was a large on-going project of community regeneration and the local residents were in the process of being relocated to other housing estates. It was clear that this process was stressful for local residents and people were unhappy about their local authority's decision regarding reallocation. They felt that they did not have a say in the decisions made by the authorities nor were they listened to. Residents believed that the local authorities were *"not upfront and truthful with the residents"* and there was no point taking part in any consultation led by the government agencies.

Another problem with regeneration areas was that reallocation uncertainties made it difficult for residents to engage, as many people did not know for how long they would belong to that specific community. This was especially true in Ealing and Hackney where large regeneration projects were going on and people were being moved.

There were also barriers resulting from the conflicts between different local stakeholders, including the co-host organisations. Some community groups felt that the co-host organisations selected did not adequately represent their communities, and decided to ignore the consultations, as a resident in Westminster explained:

- *"There seems to be unresolved issues between [the] co-host and BME communities"*

Another issue particularly evident at the CAWs was an apparent competition between some local community organisations and the WL alliance partners. The local groups feared that the bigger, more established organisations had more resources and could take over some of their roles or duplicate their efforts in the community. The local groups wanted to protect their territories against what they saw as a predatory invasion which could jeopardize their activities and further funding. Thus, at the Ealing CAW there were suggestions that the external agencies were coming into the community to take over things that they were already doing for themselves:

- *"A lot of things are already happening and we have groups… facilitating these. We don't need an external group coming in to duplicate things already happening. Rather, we need support for the local groups to continue doing what they are doing."*

It was suggested that the external organisations needed to find out what was already happening in the communities and who was already providing services and to use local resources and providers. This could make services more effective and also support local businesses and providers.

Furthermore, insufficient information was also an apparent barrier to engagement. Several respondents said that they did not fully understand what the WL programme was about and did not know how they could engage with it. The same was noted by a number of in-depth interview participants who could not fully understand the scope of the programme or the process of area selection:

"… we don't see the point of it. We don't see the point of the whole project…"
(JGE- M/60/Local Councillor)

Some did not think it was worth their time and effort to try and understand the programme because they felt it was another government schemes which would go ahead despite their opinions of it. They felt that health promotion projects like the WL was just another way of telling them how to live their lives. There was also a suggestion that the programme was not suitable for the socio-economic class the target population belonged to because health promotion programmes were better accepted by higher socio-economic classes.

> *"Most people resent the concept of Well London and similar projects, as an invasion of their privacy…they call it around here, 'the broccoli police'. It is regarded as an invasion of people's privacy; government directing them how they are going to eat, how they are going to have their entertainment. It might go down well with the middle class, but it certainly doesn't go down very well with the working class". (JGE- M/60/Local Councillor)*

Another barrier mentioned by the study participants was residents' frustration and apathy towards repeated consultations without any evidence of subsequently addressing their expressed needs. Some residents said that community consultations in many areas had become a *'tick-box'* process which yielded nothing other than satisfying the statutory requirements. They gave several examples of where they were consulted on various issues which later turned to decisions made against what they wanted.

- *"… there have been consultations held, for example, about the park. People came out in large numbers, and what happened? They (local authority) still went ahead with their plans. There needs to be open policies where people know that what they say will be taken on board and acted on."*

Another problem mentioned by the study participants was the prevailing economic difficulties in the country which had affected not only individuals, but also the development of communities. Many regeneration projects were abandoned and local people were left in limbo as to what the future of their housing would be.

- *"…the credit crunch has slowed down development and this has demoralised the community."*

A number of logistical and organisational issues were also mentioned. At the CAWs, respondents reported that they encountered barriers with the venue.

These barriers included acoustics problems, unfamiliarity with the venue and the association of the venue with particular community groups. One participant in Ealing, for example, explained how poor acoustics in the community hall affected his participation:

- *"the acoustics in the building is very poor...I had to endure the sound"*

Language was also a barrier to engagement especially for the residents whose first language was not English and who did not understand or speak the language. Although the posters and leaflets had some translations into other languages, the sessions themselves were conducted in English. Translation was not possible in every session because of the format of the cafés. Some participants raised the issue of passing information about the events to residents. First, they mentioned literacy, not only for those whose first language was not English, but also for those who could not read English even though they were native English speakers, as one resident explained:

> *"...you've got a large number of people who...'don't speak English' [and who] 'don't read English'. And that applies to people who have been educated in English schools, as well as people who've just arrived. So, giving out leaflets doesn't always encourage people...a lot of people don't speak English so they don't know what's on the leaflet anyway"* (JGE- M/60/Local Councillor)

Another problem was the distribution of leaflets about the event in the blocks of flats. Many tower blocks had the intercom entry system which required that someone had to let the leaflet distributor into the building. If there was no one to open the building door, there was no way of getting the leaflets to individual flats. This reduced participation of the residents from such tower blocks:

> *"We don't always… get post up here because…people have to be let in to drop the mail."* (CCB- F/30/Housewife)

> *"A lot of leaflets don't get delivered; a lot of people delivering the leaflets can't get into tower blocks because they can't get through on the intercom systems."* (JGE- M/60/Local Councillor)

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7.4.3. Ways of Encouraging Community Participation

The overwhelming majority of café respondents felt that providing information and better communication, and particularly early advertisement of the events would help involve people in the community activities. Many respondents mentioned notice boards, leaflets, newsletters, regular meetings and social events, provision of refreshments, and provision of children's play area. In-depth interview participants also noted that the events needed to be well publicised and the themes of the event needed to be of interest to the residents. It was argued that the issues which were topical and current and which affected people's lives were more likely to increase participation, as one participant explained:

> "Generally… if they are well publicised, not only by leaflets but also by groups of people going round and reminding other people; and if it's a very important issue such as what is going on at the moment…they will come." (JGE-M/60/Local Councillor)

Another interviewee expressed a similar opinion:

> "I would say your best bet is to just try and find out what people actually like...and advertise it over a longer period of time. Give people more notice... [be] more flexible." (MRB- M/27/Recycling Collector)

A number of participants discussed relevant topics of high concern to the local communities. Among the key issues identified were crime, safety and policing. For example, a participant from Ealing described how these topical issues were used to engage his community residents:

> "…the police…had a week last summer…that had much more support from the community because talking about policing issues like drugs dealing and community safety and protection from thieves and robbers; that's more appropriate. That's more a community concern than what they are going to eat." (JGE- M/60/Local Councillor)

Another topical issue mentioned was community regeneration and housing redevelopment. Other activities named included livelihood, employment and financial matters. It was argued that the discussions of these issues could increase participation because participants could see an immediate gain from

their involvement. Some argued that people's involvement could be increased by making consultations directly relevant and beneficial to the participants. For example, for a family with a special needs child, community activities which will provide signposting to the relevant services for that child would be essential and would keep them engaged.

"I have a child with a disability, but I'm not really well informed about the possibilities, I mean where she can go and what can help her to be better." (SVE- F/44/Dietician, Homemaker and Carer)

It was argued that the dissemination of information can be through multiple sources including information technology. The use of different communication approaches could ensure that information trickles down vertically through organisations and spreads horizontally through the community:

"We rely on...a combination of things. I do an email once a month to all the Churches, mosques, community associations, voluntary organisations, and neighbourhood watches that I've got email addresses for. And then I rely on them passing them on to, either in their own newsletters or by emails to their members." (JGE- M/60/Local Councillor)

Some respondents wanted to be contacted personally by visits, telephone calls, emails or letters; others preferred a more general community contact through posters, community newsletters; a few preferred to get their information from specific projects in the community. The respondents who said they would like to be personally contacted said they were more likely to participate or attend a community activity when invited in this way because it had a personal element to it and there was more pressure to be involved than if they got invited by leaflet drop or posters.

"...we are in the life where we contact people by machines, computers and we sometimes need human contact; to see people, to have the people put a little bit of pressure, to ask us to come. Sometimes it's sweeter; it's more human you know, than to just receive a cold mail." (SVE- F/44/Dietician, Homemaker and Carer)

Some however noted that communication through emails, telephones or visits presupposes that the resident has in some ways already made contact with a

community service or organisation where the contact details were collected. These methods of communication are also very expensive and time-consuming.

Some said that where leaflets are used to communicate information, it is important that the leaflet is attractive and catches the attention of the reader quickly. It should also be easy to read and the important information easy to find because people lose interest quickly in leaflets that are dropped in their mailboxes because of the huge amounts of junk-mail received daily. A respondent suggested that a leaflet had a maximum of five seconds to grab ones attention or else it was dumped into the dustbin.

Some participants said that it was important to involve local organisations and groups of interest as many people are already part of these groups. Many participants reported that they got involved in community activities through their engagement in organisations and groups of interest. Others mentioned the involvements through age-group clubs, inter-generational activities and common-interest groups. It was noted that it is easier to engage people when they are already engaged in a group or activity because they see further engagement as an extension of their current involvement. People also find it easier to get involved if other members of their existing group or family are involved in the same activity, and they are encouraged by the peer involvement because they know they will not be alone or be the only member of their group at the event. Others argue that involving children was a good way of getting people engaged in community activities because children acted as catalysts for socialising amongst their parents and other members of the family:

> *"I do think different clubs and things like that are very good ways of getting people together because for one thing, it brings the younger generations together. And when children are together, the adults get together." (LWB-F/31/Student and Mother of three children)*

Another participant expressed a similar view:

> *"And I do find that...once you've got a child, it's easier to talk to people in the community because they might have children and you might have something to talk about." (LWB- F/31/Student and Mother of three children)*

Schools are present in every community and are ready opportunities for engagement as a hub where most people have a connection. Participants said that information could be passed through the schools to the children and on to the families; or children could be encouraged to participate, thereby involving their parents. A participant explained her engagement through school activities:

> *"…like at my son's school, I speak to some of the parents' around there and see sort of what's going on…I know last time the kids actually brought letters home from school which was really good because I don't always see the posters if they are in the shops." (CCB- F/30/Housewife)*

A number of interviewees noted a downside of using community meetings for communication because not everyone attended them, and those who did were usually already engaged anyway; thereby excluding a lot of people in the community.

Involving local businesses and enterprises such as community halls, restaurants and fast-food shops, laundry, pubs and convenience stores was also seen as an important way of getting information across to the community because these are the places residents visit regularly in the course of daily activities and no extra effort on the part of the resident is required. In Hackney, the respondents identified the local laundry as a hub of information because many people go there and they chat while they do their laundry.

Another key approach mentioned by interview participants was having community events at the time convenient but safe for residents to attend. It was argued that if events were held during the day time when people felt safe enough to go out, they were more likely to be attended.

Finally, a number of participants mentioned that devolving power and influence to the residents and building trust between the authorities and local residents would also be essential to encourage people to believe in consultations and come to express their views.

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7.5. Impact of Community Engagement Process on the Communities and Projects

In this last section, the researcher looks at the actual impact of the WL CEP as was ascertained and described by the community residents that participated in the cafés and CAWs.

7.5.1. Benefits of the CEP for Communities

The study identified a number of benefits of the CEP, as perceived by the café, CAW and in-depth interview participants (Figure 7.5).

Figure 7.5 - Beneficial impacts of the community engagement process

Benefits

➤ Knowledge and information about the programme
➤ Signposting to the local services
➤ Improved knowledge of available local services
➤ Integration of new residents into the community
➤ Opportunities to get to know one another
➤ Opportunities to share ideas
➤ More cohesive community due to intergenerational and intercultural interactions
➤ Increased interest in health and healthier lifestyles
➤ Perceived empowerment of the community

First, the respondents said that the CEP provided them with an avenue to get information about the projects that would be delivered in their communities by WL; and a chance to find out some of the activities they might be interested in. In Ealing, a qualitative interview participant found out about video-filming classes organised by WL in her community and she attended the classes and acquired skills which increased her work prospects and improved her general wellbeing.

The CEP provided an opportunity for signposting the services available in the community. Another resident in Ealing said that she had found out about local activities available for her autistic daughter and this made a significant difference for her family.

The CEP was especially beneficial for people who were new to the community because it gave them a chance to meet with other residents and to find out more about services and activities in the area. Integration of new residents to the community, therefore, was another positive aspect of the WL CEP. Furthermore, integration was not limited to the new residents in the neighbourhood. Some residents who had been in the community for many years but did not feel part of the community had an opportunity to learn about their area, who lived in that area, which organisations worked there, and which services were available for them, as one resident explained:

> *"I moved here just after Christmas, I think it was 2007. I think I've been here two years in total now. But it was really handy to get to meet people and know what there was on in the community…I found out about Acton Forum running activities in here, like they have bingo one evening a week and we now have carpet bowls and darts. If I hadn't come to that meeting, I wouldn't have met people to tell me things later on." (CTE- F/34/Housewife)*

The CEP also enabled the community to come together informally to share ideas and get to know one another. The local residents of different backgrounds, ages and cultures had an opportunity to interact with one another, and thereby build trust and respect:

> *"The advantage of it is that you meet with so many kinds of people, with different organisations…You meet friends, you talk to each other." (BOH- F/66/Retired)*

Another participant said:

> *"Yes, it was nice meeting some other people who I didn't know at all; and just have a chat about different things, and everybody having different ideas." (LWB- F/31/Student and Mother of three children)*

Intercultural and intergenerational communications were particularly emphasised by the interview participants.

> *"The advantage was to get to know your neighbour who is living next door and speaking to them…we have a lot of a lot of multicultural…It was nice to meet up with them and their children. Some of the children go to the local school that I work at, so that was very good…Plus, a lot of the grandparents don't get out*

much but the grandchildren brought them along and they mixed with a lot of the neighbours." (JAH- F/58/Dinnerlady)

The engagement process helped members of the community to acquire health information or knowledge relevant to their circumstances. A participant in Barking and Dagenham explained how the CEP helped to get her son more active at no cost to the family:

"...it helps give my children things to do. My son has a weight problem; so on the weeks like half term when we didn't have spare money to take them out, there (were) activities going on over there and so it was something for him to do every day so he's not stuck in front of the telly...we can...get involved in as a family...I mean, my son's a lot more active now because there is more going on and it's all free, and for us that's a real big help because it's only my husband that works." (CCB- F/30/Housewife)

Some café and CAW survey participants mentioned additional benefits derived from the CEP. For some, the WL consultation acted as a feedback mechanism about the actions taken regarding previous consultations. For some, it enhanced the environment by engaging the communities in the planning and use of communal and green spaces. Some said that the process encouraged some residents to develop healthier habits. It improved communities' mental wellbeing, strengthened the community spirit and improved cohesion through socialising and networking.

Some said that the process led to better integration of services by filling gaps and building on the existing infrastructure, skills and resources. Some argued that overall, the process did empower the communities and increased their influence over local services.

7.5.2. Impact of CEP on the Design and Delivery of Projects

One way through which the community consultations were expected to influence the WL interventions was that the activities proposed by residents were taken forward and integrated into the projects delivered in those areas. The in-depth interview participants were asked to which extent they believed it had happened. The answers to this question varied, and the feeling among the interviewees were rather mixed. It was argued that the key positive impact of

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the consultation process was that it raised community interests and expectations for the projects proposed. People in many areas did believe that something different was going to happen in their areas. However, to which extent the projects proposed met these expectations remained an unresolved dilemma for the participants interviewed.

In fact, the majority of the respondents said they did not think the consultation had any major impact on the projects, either in terms of their types or in terms of their content. Thus, several participants believed that many concerns and wishes of the communities expressed during the CEP had not been taken into account in the projects. Thus, one participant in Hackney who attended both the café and the workshop, pointed out that the football promotion project proposed by the local residents during the CEP had not been taken forward in further discussions and had been excluded from the final area plans:

- *"somewhere between the needs analysis and the projects, the issue of the football field mentioned at the community cafe has been overlooked"*

Some respondents said that they had heard about the projects at the CEP and had actually participated in them subsequently:

"I came on filming courses with Well London which was really good. They ran a crèche for that day... which is fantastic." (CTE- F/34/Housewife)

The opinions on the impact of the CEP on people's participation in WL projects varied. Some said that the CEP did raise awareness of the projects in the communities; it let people know what was happening in their neighbourhood.

"... people are aware of what you guys are doing." (CGE- M/58/Self-employed artist)

A number of interviewees, however, thought that the consultation process had not managed to increase the visibility of the WL programme, and not many people knew or talked about it, as a participant from Southwark noted:

"...for the residents, nobody ever seems to mention Well London." (INS-F/70/Retired)

One explanation of such low visibility offered by the participants was that the local situations in the areas had changed rapidly, and other community priorities overshadowed the WL programme. Some attributed it to the six to twelve months time-lapse between the community engagement and the actual delivery of the projects. Many interviewees said there were no immediate noticeable changes observed in their areas following the consultations, and this was frustrating:

> "…nothing's ever happened since after we had that little meeting…It was just like it was a one-off. Even my local neighbours are saying, 'when are they going to have that again?' And I say, 'well, I haven't heard anything since!'" (JAH-F/58/Dinnerlady)

A participant in another area described very similar feelings:

> "…there are supposed to be health projects, there are supposed to be Arts Council projects...But none of them have contacted me and nobody who lives in South Acton have said they have contacted them either." (JGE- M/60/Local Councillor)

Some said that there was little information about the programme immediately after the engagement events and people either forgot about WL or refocused their attention to other activities:

> "I have not heard of anything that has gone on and I was part of the thing [community consultation]…if you're not even telling people who were part of it..." (LWB- F/31/Student and Mother of three children)

Some said that sometimes it was difficult to identify whether the projects were WL activities or projects of another organisation. This was particularly the case in the areas where there were various activities going on and the residents mixed up the projects delivered by different organisations and funded by different sources. The respondents had very little information about the projects and are likely to have mixed up some of the projects with others funded by another source.

> "I know there (are) projects going on but I don't know if they are actually by the Well London or not." (CCB- F/30/Housewife)

Some people said that WL activities often built on the existing initiatives, which on one hand had a positive impact on the sustainability and continuity of these existing interventions. On the other hand, however, the overlap between the project activities undermined the identity and visibility of WL itself.

Some participants linked the lack of any substantial impact of the CEP to the types of interventions proposed. It was argued that some of the projects proposed were not what the communities had anticipated following the CEP, and many local residents were not in support of what was eventually proposed. In Barking and Dagenham, for example, smoothie bars and other healthy eating initiatives were suggested at the CAW and the idea was then taken forward at the PIM. A resident who participated in the café believed the idea was totally inappropriate because healthy options were already available in the local supermarkets; and small fast food shops were not in the position to sell healthier food as they could not compete with supermarkets and many people could not afford buying such things as fruit smoothies:

> *"...the smoothies bars are going to be a waste of money…because… it costs too much; parents haven't got the money these days..." (MRB- M/27/Recycling Collector)*

Some participants argued that the projects were not a high priority for many of these areas, and particularly where people faced other major issues such as area regeneration and reallocation of residents, or very poor housing conditions. The interviewees argued also that residents were going through very challenging times economically and were unlikely to be made happier or healthier by, for example, arts projects:

> *"…the projects… doesn't seem to be at all appropriate to an estate where there is a lot of uncertainty because the blocks are being pulled down and a lot of people are having to cope with transfers around the area or even out of the area and with possibly new people coming into the area.." (JGE- M/60/Local Councillor)*

Chapter 8 – Results:

Community Engagement Process and its Impact – Local Community Organisations' and Stakeholders' Perspectives

8.1. Introduction

This chapter presents the findings of this study from the perspectives of the local community (voluntary sector) organisations (CVO) and other stakeholders in the target areas of the WL CEP.

The chapter examines the organisations' expectations of the CEP and reasons for participation; what the organisations found particularly good about the process and what could be improved; the key incentives for and challenges of the CEP, as perceived by these stakeholders; and the impact of the CEP on communities, their own organisations and WL projects.

8.2. Characteristics of Participant Organisations

Organisations that participated in the CEP evaluation were largely CVOs that were based in the target areas. Many had been serving these communities for years and had good relationships with, and respect of the communities. Some organisations focused on specific groups such as the elderly, minority ethnic groups, tenant groups and community volunteers.

The organisations that participated in the phase-one evaluation were co-host organisations supporting the CEP in phase-one areas. Out of these nine co-host organisations, only co-hosts in Brent, Croydon and Greenwich responded to this open-ended question survey.

Organisations that participated in the CAWs included co-host CVOs and other stakeholder organisations based in the communities. The latter group included statutory, private and third sector agencies that were not CEP co-hosts. They were invited to the CAWs because had a good knowledge of the communities

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and could contribute to building local relationships and networks. These organisations represented the majority of CAW participants. In areas where the CAW survey was conducted, their proportion ranged from 40 to 60% of the total CAW participants. In total, 50 the 63 CAW survey respondents represented CVOs. The individuals who represented these organisations performed a range of professional functions at both managerial and technical levels.

Participants in the qualitative interviews were individuals from co-host community organisations involved in the CEP in phase-two target areas. Some were also involved in the delivery of some projects which followed the process. Six individuals from four community organisations representing the boroughs of Barking and Dagenham, Ealing, Hackney, and Southwark, participated in these interviews.

8.3. Perceptions of the Well London CEP

Generally, the co-hosts and other stakeholders felt that the CEP was a good positive experience which had a potential to reach and benefit the local communities they served.

> *"... overall I think it's a very positive project and it can achieve positive outcomes... it is well-thought out." – SFE*

The community organisations particularly appreciated the community café which they said was an honest approach to engaging the community because it encouraged a two-way communication, and was different from the 'usual' community consultations whose objective was to "tick a box".

The co-hosts in Brent and Croydon felt that the community engagement events in their communities were not particularly successful given the turnout of residents at these events despite the awareness raised prior to the events. Another café had to be organised in Brent, targeting particular community groups, but this also had a low turnout. Similarly, in Croydon, street interviews had to be conducted to supplement information derived at the cafés. However, in Greenwich the co-host felt that the community engagement was good and was well received by the residents.

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8.3.1. Reasons for Participation

The motivation for participation varied among the organisations. Most local CVOs and stakeholders were invited to the CAWs and PIMs as they were considered to be key local players who could contribute to the engagement and development of the communities through networking and possible project delivery. Co-hosts were expected to take part in all CEP events as part of their responsibilities as co-hosts.

8.3.1.1. Reasons for Being a Co-host

Most organisations said they agreed to be co-hosts because they wanted to achieve positive changes for their communities using new ways of community engagement offered by WL. They said that they were interested in the new model of engagement used by WL the World Café model and the appreciative enquiry approach); and hoped that they would benefit financially through the programme delivery grants (figure 8.1). However, the co-host in Greenwich said that there was little financial benefit for their organisation from the CEP, and engagement was achieved through their existing channels.

Figure 8.1 – Expectations and reasons for participation

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Reasons for participation

➢ To achieve positive outcomes for the communities

➢ To learn new ways of engaging the communities (World Cafe and AEW approaches)

➢ To play a role in reaching out to the people

➢ Financial expectations for the organisations

➢ To be part of a large scale programme

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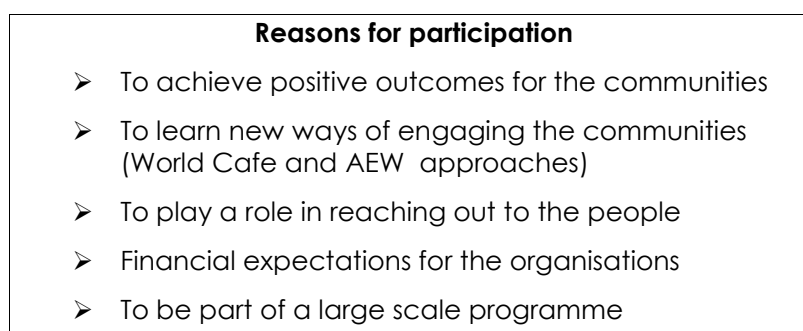
The CVOs hoped they could learn new ways of working with the communities and looked at WL as a pilot for their future engagement processes:

> *"I think some of the approaches have been slightly different. There's been a few new ideas…we hadn't tried before and yes, I think it's been useful." – SFE*

> *"…we're always willing to try out new alternates to community engagement; new initiatives." – EAH*

The co-hosts saw their role in the CEP as a 'go-between' with the purpose of reaching out to people, giving information about the programme and getting

as many residents as possible to attend the events. They said this was something they were good at and something that they saw as an integral part of their organisational mandate:

> "…my job was to get bums on the seats…and let the residents know what was going on and why it was important for them to attend." – LME

In addition, many of the co-hosts expected some financial contributions from the CEP. WL was a new source of funding which could sustain and support their organisations. Some said that they wanted to be a part of WL because of the large scale of the programme and its potential resources. The programme also promised to leave an important legacy in these communities and the local CVOs wanted to be a part of it.

8.3.1.2. Reasons for Participating in the CAWs

Most participants at the CAWs said that they attended because they had been invited as part of their work. All were organisations already working in and with the local communities and had first-hand knowledge of these communities through delivering different projects.

All participants said that they wanted to see what the WL programme was about so that they could report back to their organisations and find ways of being involved. The organisations saw WL as a new important player in their communities and wanted to make sure that their organisations were involved in this new big initiative:

- "[We wanted] to ensure our organisation was not excluded"

Some stakeholders came to represent their specific target groups and wanted to make sure that their groups benefit from WL:

- "[We came] to represent unpaid the family carers that are resident in Westminster"

- "[We came] to promote Healthy Walks"

- "[We came] to expand box scheme and allotment on the estate"

- "[I came to] put forward an idea I have about supporting 16-25 year olds"

Others said that they wanted to ensure that WL did not duplicate the existing projects and structures within the community:

- *"…to ensure we share agendas and that Well London builds on existing structures and projects"*

8.3.2. What was good about the CEP?

The co-hosts organisations thought that overall, the process was interesting and effective. Other good aspects of the CEP are highlighted in figure 8.2.

<u>Figure 8.2 – What was good about the CEP?</u>

What was good about the CEP?
- ➢ Good approaches for engaging the communities, e.g. World Cafe approach, AEW approach, street interviews
- ➢ Support from Well London alliance partners
- ➢ Built new relationships and networks
- ➢ Facilitated local agencies and groups to work together
- ➢ Diversity and range of participants
- ➢ Skilled facilitator
- ➢ Opportunity for networking and sharing ideas

The co-host in Brent found the CEP useful for her organisation because they had got to know the area and the local residents better, they had met the professionals working in the area and had got a first-hand experience of different community engagement techniques.

The feature of the process that the co-hosts found particularly useful was the new methodology of engagement. They said the cafés in particular gave the residents an opportunity to express their needs at their own pace and in a way that suited them best:

"I think it's quite good because [of] what it enables people to do…because it's in small groups, you get people who normally are fearful of large groups…participate a little bit more" – DRS

The co-hosts said that the street interviews conducted in the areas helped them identify and engage community members. This approach helped to reach people in a way that was non-threatening but supportive.

"Yes…we tend to use the same body of residents…that get involved in different projects, but via this process…we were able to build relationships with different people." – LME

Another good aspect of the CEP identified by the co-hosts was the support they received from the WL alliance partners. Although not all the organisations said they had experienced a good level of support and communication within WL, many of them were happy and satisfied:

"...there has been a lot of help and support from Groundwork." – DRS

The CEP also helped to bring different local agencies and organisations together for the common good of the communities they served. The process provided a focal point through which different activities were delivered by different stakeholders who would not normally work together.

"…it's definitely provided a focus for activity which has been good …and forced a few agencies to work together that wouldn't normally work together." – SFE

The co-hosts also found the appreciative enquiry process valuable because it helped them to focus on the positive aspects of the community and how these could be used to meet local needs. The workshop was identified as a good way of networking and facilitating partnerships. The CAW participants felt that the diversity and range of workshop participants was very helpful as it allowed them to share ideas with a large number of people they had never met before. Many participants praised the appreciative enquiry process and the skills of the workshop facilitator.

8.3.3. What could be improved?

The co-hosts dwelt more on the process itself while the other organisations focused more on the issues around community engagement. The areas identified are listed in figure 8.3.

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Figure 8.3 – What could be improved?

What could be improved?
➢ Operation of the process
➢ Simplification of the process
➢ Engagement of some groups of community members, e.g. younger people, men
➢ Communication and feedback
➢ Better understanding of community engagement at a local level
➢ Better understanding of partnership working

The operational matters highlighted by the co-hosts included the need for clarity of objectives and roles, timing, and resources. It was argued that there was no shared understanding of how the CEP should be delivered. The goals and objectives of CEP had been determined before the co-host involvement and it took them some time to get their heads around what the process involved. The CEP was complex in a number of ways; it involved multiple stakeholders operating at different levels and multiple outcomes were expected at each engagement stage. There was also little clarity about the resources and how they could be used. This complex nature of the CEP created a substantial administrative burden for many organisations who did not get any additional resources to deal with these issues.

Furthermore, the CEP was full of new terms and acronyms that were difficult to understand and remember. Many local organisations felt that there was too much new information to take on board in the relatively short period of time:

"…too many silly acronyms" – LME

"…there is project-overload, activity-overload, you know...it's too much coming at one time." – DRS

Another area that was identified was the engagement of certain population groups. Young people and men, in particular were not adequately engaged in the process and the participants wanted to see a variety of ways of targeting and engaging specific community groups. They suggested some strategies for diversification such as modification of the session content, timing of the events, and better understanding of the barriers characteristic of these groups:

"There was definitely bias towards more females there." – LME

Another issue was improvements in the communication and feedback loop. The respondents said that the communities needed to have a response about the issues discussed at the consultations. The organisations interviewed felt the communities were not given enough feedback in relation to what was discussed at the CEP events, and the process through which the final decisions about the projects were made. They recognised that not all issues could be addressed but emphasized that future engagement could be affected by poor communication.

"…unless you explain and go back to the people that you consulted with and you basically close the process, the consultation is not valid for that particular group – (EAH)

Some of the issues around communication were linked to the hierarchical organisational nature of the CEP where individuals at strategic decision-making levels made certain decisions which did not work well at the local operational level. Examples of these are the inflexible time schedules for the CEP and the uniformity of the process with insufficient understanding of individual communities and their peculiar characteristics, both of which affected how the engagement process was delivered.

The participants suggested that the agencies involved in community engagement should work in partnership, with good communication and understanding; and that those who work at strategic levels should become familiar with the issues faced by those working on the ground so that they can make adjustments to the processes, schedules and procedures. The procedures should be flexible and allow for rapid modifications both at the planning and implementation stages:

"If they don't know how to work in partnership, particularly with those of us who are on the ground, and in a transparent way, it's not going to work or it makes it very difficult to work; it'll take longer." - VEB

Some smaller community organisations felt dwarfed by the larger ones and felt that the larger organisations took them for granted and often ignored their ideas and suggestions. Larger organisations issued directives and there was no dialogue on how to engage communities in which the local partners had

worked for years and where they were well-known and trusted. The respondents wanted the local community organisations to take a more active role in the CEP as these organisations were part of the community and had the best access to the residents. The respondents pointed out that there was a lot of top-down communication within the WL team and many decisions had not involved local organisations.

"Do not take us smaller organisations for granted especially when you are coming to our own patch which we've known for years...big is not always best." – DRS

Some organisations said that a "one-size-fits-all" approach forced on target areas caused many problems. The programme ignored the fact that the approach that worked well in one community would not necessarily work in another one. They recommended that future engagement projects should be adapted to the local environment because projects are sensitive to what is happening locally.

"It's also important to work within the [local] boundary, within the [local] structures and to the advice of what's happening locally..." – VEB

The CAW participants wanted to see more local residents at the workshop. They felt more efforts should have been made to involve local populations. Increased participation of residents, in their view, could have ensured higher levels of continuity between the cafés and the CAWs. They also thought that the CAWs could be a good opportunity to feedback to the residents that participated in the cafés. This however did not happen because of the low levels of involvement of local residents in the CAWs.

In a couple of areas there were complaints about the CAW facilitation and acoustics, but these complaints were more of an exception than the norm. Other suggestions for improvement included early development of job descriptions for various roles in the process; negotiation for provision of time extensions; more robust introductory workshops for co-hosts; better publicity and improved publicity materials taking into consideration local contexts; clear communication about the different steps in the process; better remuneration and early payment for co-hosts; and interactions between co-hosts in different areas and linking up old co-hosts with the new ones for the purpose of learning.

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8.3.4. Lessons Learnt from the CEP

The co-hosts and other local stakeholders identified five key lessons they have learnt from the WL CEP (figure 8.4).

Figure 8.4 – Lessons learnt

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Lessons Learnt

➢ Importance of timing and scheduling of community events

➢ Importance of building relationships with the community

➢ Importance of managing expectations

➢ Importance of good timely communication

➢ Importance of flexibility

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The first lesson is the issue of timing. The events, particularly the meetings which involved both professionals and residents, such as the CAWs and PIMs, should be timed more conveniently for the local residents and not the agencies that organise the CEP. In the WL CEP, little consideration was given to the residents' routines and daily priorities which prevented many from attending the CAWs and the PIMs:

> *"They organised it on a Monday morning at nine o'clock when everybody is at work and even those who are not at work… go and collect their benefits… it [timing] completely isolated all of the tenants and residents." – DRS*

Furthermore, community consultations should be linked with other community events which already hold community interest so that attendance could be increased. For example, if a community meeting or a festival is already planned, the community engagement event should take place at the same time. Such timing can also diversify the range of local participants where people with the interests in neighbourhood safety or education could meet those interested in healthy eating or green open spaces.

> *"…if there is an event they've already planned, we'll then merge into that if we can, if time allows." – DRS*

The co-host in Croydon felt that the CEP was extremely rushed and this tight time schedule might have been responsible for the poor turnout of residents at the community engagement events and the low level of buy-in from the members of the community. There was a need for time, especially in a borough

like Croydon, where there was a history of apathy and scepticism around community engagement, and because there was no local organisation who had established links with the target LSOA at the time of the CEP. Another issue stressed was personal safety. Some events were poorly attended because they were held after dark and the residents feared crime.

The second lesson learnt was about the relationships with the community. The WL CEP did not build in enough time for developing such relationships, nor did it have time to research these communities and their specificities in any detailed way. Information about the areas was derived from a desk-based research exercise which did not reflect the true picture on the ground. The participants suggested that a desk-based research should not be relied upon fully in profiling the communities. Building relationships should be a flexible and creative process which happens on the ground.

> *"You have to use what's locally available regardless of the desk-based research that takes place…so you have to be a bit more creative." – VEB*

Managing expectations was another important lesson noted by the co-host organisations. The local organisations interviewed felt that the expectations of the WL programme had been unduly raised during the CEP, and many of these expectations had not been met at any time either during or after the engagement. For example, the residents were given the impression that they would be solely responsible for deciding the projects delivered in their communities and that there was a certain amount of money available to them for these projects. The programme did not explain what the decision-making process was and how the money would be distributed. These unmet expectations led to the feelings of disappointment.

> *"...one of the things I was very keen on from the start of the project was not to raise the expectations of the residents because that has happened quite a lot." – LME*

> *"I think they [WL] are just setting people up for giving high expectations out of this whole project when really and truly, they knew there wasn't much money." – DRS*

The need to communicate more effectively with the community was also identified. It was argued that in WL, there was no feedback on how and why

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the specific projects had been identified. The co-hosts said that there had been an initial wave of optimism about the process which was largely lost later when there was no on-going communication with those who had been engaged earlier in the process. This was particularly frustrating because similar problems had been experienced in the past and many residents had lost faith in the delivery organisations that consult them and never come back with the outcomes of the consultation.

Finally, many respondents talked about the need for flexibility in delivering CEP. Many said that community engagement should be tailor-made for each community, taking into consideration each community's characteristics and history of engagement.

> *"…flexibility around community engagement…If that's not adhered to, then the engagement that you're looking for won't be fully realised." – VEB*

8.4. Incentives and Challenges of CEP

This section examines what encouraged local organisations and those who represented them to participate in the CEP and the challenges they faced in the process.

8.4.1. Incentives for CEP

The researcher asked community organisations to identify factors that they believed encouraged their local residents to take part in community consultations and events. The factors named are presented in figure 8.5.

Figure 8.5 – Incentives for community participation

> **Incentives for Community Participation**
> ➢ Free activities and events
> ➢ Accessibility
> ➢ Issue of importance to the community
> ➢ Be a part of a change process (to make things better)
> ➢ Volunteering and employment opportunities
> ➢ Get information
> ➢ Socializing and networking
> ➢ Financial or monetary incentives
> ➢ Food and entertainment

The first factor identified was the ease of the process of engagement. It was argued that the residents were more likely to come along when the events were free, easily accessible and convenient, and took little effort on their part:

> *"...it's got to be free; that's number one." – DRS*

Some noted that the events held in local neighbourhoods reassured the residents that the activities were specially arranged for them and would address their issues and concerns. Some further argued that the residents are likely to be motivated by important and topical issues, something that concerns them and what they wanted to discuss:

> *"...something which the community actually needs and has been identified as a need by those individuals" – DRS*

The respondents said that the events also had to be entertaining and provide opportunities for fun and leisure. The issue of safety was also stressed. The events had to be done locally, timed for when it was not too dark, and where children could be supervised and feel safe.

Many noted that most people get involved in community activities because they want to see a change in their community and this expected change can be an important incentive to participate. For this group of people, they would usually mobilise around a particular issue of interest but may not participate in other community activities.

> *"If they've got interest in or if they've got a stake on the issue that's being discussed." – EAH*

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Some said that many community residents see local projects as an avenue for jobs in their community. For other people who may not be looking for paid employment, volunteering in the projects is an avenue to contribute to their communities and to gain new skills. This in turn can lead to better employment opportunities or boost self-esteem:

> "...the incentive for people to get involved is kind of improving their esteem about themselves, making them feel worthwhile. I think that there are a number of people who are motivated by protecting the environment… there are a number of people who are motivated by wanting to give young people something to do… people get a kind of sense of self-worth and pride about the community. I think that's a big incentive." – SDH

> "…there is a lot of unemployed people; but it's not unemployed people who can't find a job because there is mass unemployment, it's because they are long term carers, or they have long term illness or disability…they may…be able to volunteer a few hours a week and…get involved in the community." – SDH

Some argued that many people got involved in community activities because they wanted to get information about existing services in their communities or about the ways to live healthier or safer in their communities. For many others, it was also a good way of getting to know their neighbours and socializing:

> "Some of the people who came to the events, they were people who were new in the area and didn't have the support network…that could be really very isolating…they may find others in the same positions; they could build up relationships, friendships that way too...mixing with different people, giving you the information and letting you know what other groups you can access..." – LME

Some respondents mentioned that financial incentives may be important, particularly for young people; others noted the opportunities for free food and entertainment as an incentive:

> "… sometimes people would like some sort of financial or other incentives, especially young people, to participate. I suppose, what we are talking about there is them, feeling that their contributions is going to be valued, whatever value system you use." – SFE

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8.4.2. Incentives for Stakeholders' Involvement in the WL CEP

The community organisations interviewed identified several types of incentives that encouraged them to get involved in the CEP. Firstly, they wanted to be involved with a project that developed the communities they served. They also wanted to be associated with a major programme such as the WL, to learn new approaches for engaging communities, and to obtain funding (figure 8.6).

Incentives for participation (community organisations)
➢ Community development
➢ Association with a major project
➢ Learning for future community engagement
➢ Funding
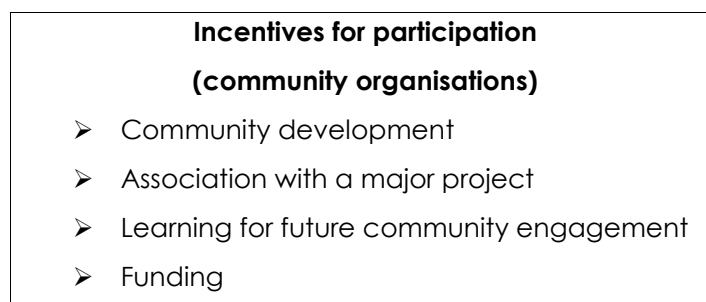
The organisations viewed their association with the WL CEP as an opportunity for organisational growth and visibility. WL programme is a large programme with some major organisations being its alliance partners, and many local organisations said that they wanted to be associated with such a big initiative which promised to be a success story and a landmark in community development in London. They believed that this association could bring along recognition and future funding for other projects.

> *"...we feel it's a worthwhile project and we also feel that it will be sort of a flagship project for us if it is successful, so we can use that in levering more support for our organisation which could then draw more funding in the future." – DRS*

Many organisations saw the WL CEP as an opportunity to learn about new approaches to community development and so it was a learning process for them:

> *"I think it was useful because we experienced a community cafe idea which we didn't know about." – DRS*

Some organisations knew about the World Café model and the appreciative enquiry approach but had no opportunity or funding to try them. So when the WL came along, they jumped at the opportunity to try this new idea in practice.

For many, the idea of the community being in charge of what is planned and delivered was very attractive. These organisations promoted the idea that people could move from a lower level of engagement to a higher one, which eventually led to empowerment and power control where the communities were responsible for the commissioning and delivery of the projects and services:

"…the fable ladder of participation…people moving further up that ladder so that eventually local people are sort of commissioning and owning the services…that was relevant, something to aim for…" – SFE

8.4.3. Challenges of the CEP

Two main types of challenges were identified by the community organisations. The first type relates to those encountered as part of the process of community engagement; the other relates to the problems encountered in working with the communities.

8.4.3.1. Process Challenges

Several challenges were encountered by the CVOs during the process of community engagement. The main challenge was the lack of resources, mainly financial.

Figure 8.7 – Process challenges

Process Challenges
➢ Lack of resources – financial, human and time
➢ Multi-organisational partnership working
➢ Use of a one-size-fits-all template for all areas

Firstly, many co-hosts said that they were not adequately remunerated for the amount of work and time they put into the process. This was compounded by the fact that they were not paid on time. Considering that many of them were small organisations with limited budgets, they reported that the situation put a lot of strain on their capacity to perform.

"I think they [the challenges] are largely financial, to tell you the truth." – SFE

"So we are doing lots of stuff on…shoe-string budget." – DRS

The lack of financial resources had implications for the amount and type of activities the CVOs could do. For instance, many ideas they had could not be implemented as there was no resources to support them. Many organisations had to pay out-of-pocket to cover their recurrent costs. As a result, many organisations felt resentment; they felt that from the huge pot of money available from the Lottery Fund, only drops trickled down to them. They said that most funding stayed with the major alliance organisations while most of the engagement work was done by the local CVOs. They did not see much benefit to their organisations in terms of the financial gains:

> *"But, the budgets available…are just unrealistic. Seriously, I mean, we've lost money. The money that has been available for the engagement process hasn't really covered costs...we are not in this for the money but at the same time we can't be propping up major London-wide organisations....But by the time the funding works its way down two or three levels to the likes of us, there isn't an enormous amount left." – SFE*

Time constraints imposed by WL on community engagement activities was another major challenge. Many local community organisations had to put aside their own organisational priorities in order to accommodate WL's unrealistic time frames. This had impacts on their staff and other projects they were involved in; many things had to be rushed along.

Another challenge reported was working with multiple organisations, especially where these were larger organisations that had more control and financial resources over the projects. There was a general feeling of mistrust and antagonism towards the larger organisations that formed the WL alliance partnership. The community organisations felt that they had been used when it suited the alliance partnership but often discarded afterwards. They felt that their views and opinions were not taken on board, and that the WL alliance played an authoritarian role where they issued orders and expected others to implement them:.

> *"...it's the tension between local versus national or London-wide brief and partnership." – VEB*

> *"So, I feel a feel a bit short-changed." - SFE*

> *"...bigger organisations thinking that they know best" – DRS*

An example of where the community organisation felt they were not listened to was in Barking and Dagenham where the co-host said that they had informed the WL alliance partner of the regeneration going on in the area which would involve the demolition of the community hall in the target area. The co-host said they suggested organising CEP events in another building in order to ensure continuity of the process in the same venue. However, this suggestion was ignored and as a result, the community lost its meeting venue in the middle of the process. This is how the co-host organisation described the situation:

> *"…they didn't take on the issue about community engagement with the Heath and Beacontree Heath. They knew that due to regeneration, that building would be closed because I said, 'we need to move, we need to rethink it and be flexible'. And now there is nowhere for the community to meet apart from Heath Park." – VEB*

A serious challenge for the CVOs was the use of a one-size-fits-all approach. The CVOs felt that they were well placed to suggest area-tailored modifications to the approach. However, they said that the WL alliance was insistent on using the same model for all the areas. A typical example was the design, wording and branding of the community café publicity posters. Local co-hosts wanted to use templates that the residents were familiar with to strengthen the association with certain types of activities. The WL alliance however insisted on using the same template for all:

> *"The Well London poster for the community cafe was too wordy…So even when I raised the issue about the branding, it wasn't taken up. You know, there was a tension between the local publicity and marketing, what the community are familiar with versus the Well London branding." – VEB*

A series of organisational problems affected the relationship between the WL alliance and some local co-hosts. These strained relationships served to further escalate issues because many CVOs no longer wanted to communicate with or receive communication from the WL alliance partners:

> *"And the relationship between me as a co-host and the people running that...it's not good, it's not positive." – VEB*

However, a number of co-hosts disagreed with this position, saying that they maintained cordial and cooperative relationship with the alliance partner

through the whole engagement process; they acknowledged significant support given to them as co-hosts,

> *"I think…Groundwork have been really good…" – DRS*

Some community organisation said that the alliance organisations made the CEP unduly complicated with much jargon, unusual terms and acronyms. This made the engagement process challenging for them and the community residents.

The choice of the areas was also problematic. The CVOs believed that they should have been involved in the selection of the target areas. In some boroughs, an LSOA boundary broke out the area where the residents perceived it as one neighbourhood and therefore, it was difficult to explain why some residents were invited to the consultations and others were not.

> *"...post codes are relevant but at the same time, on an estate like South Acton, you can't say, 'You lot can come in but you lot can't because you're from the wrong side of the road'. That sort of thing is absolute nonsense in reality." – SFE*

Only a few CAW participants reported some form of barriers or challenges. Time constraint was the main barrier faced by these participants. Some reported that they received a notice of the workshop very late; others said that information about where and when the workshop would be held was unclear. Some participants said that they faced challenges related to their organisations and staff. One organisation was undergoing major staff changes and another organisation was understaffed. Therefore, certain arrangements had to be made to find someone to come for the workshop. This was a comment made by one participant:

> - *"18 out of 25 members of the Community Safety Team are being made redundant, so I wondered if there was any point in my coming".*

One participant noted local politics and tensions between community organisations in the area. Thus, some local organisations did not want to attend the engagement event because of the problems with the co-host organisation and because the event was being held at the co-host's venue.

8.4.3.2. Challenges associated with working with communities

Several challenges were identified with working with the communities in the WL areas. First, there were substantial language barriers. People living in these areas were from different countries and it was often difficult to communicate with them and get them involved in the CEP. The problem was exacerbated by the use of jargon and unfamiliar terms.

It was difficult to find appropriate community spaces for the CEP activities. Furthermore, many residents had never been to some community halls and were not comfortable to respond to an invitation to attend an event at those venues.

> *"Then other issues that…were problematic in the area are a lack of venues for activities to take place." – SDH*

A number of respondents referred to fragmentation in their communities. They noted that people were often divided by age, race, ethnicity and religion; and it was difficult to conduct community events appropriate for all:

> *"I think that there is a fragmentation of the community on a number of levels; and I think that that is around age and particularly between young and older people; and there is mistrust from older people to younger people…on the estate itself…it's quite divided in terms of race…I don't think that the different ethnic groups mix as much as people care to think that they do." – SDH*

In Hackney, a religious division between Jewish and non-Jewish residents was noted:

> *"I also think that there is a religious division in the area…and there is a lot of mistrust from the non-Jewish community to the Jewish community." – SDH*

Another challenge was the rapid turnover of residents in the community. It was noted that many people did not feel part of the community as they had to move from one community to another frequently. It was difficult to engage such residents as they did not take ownership of community life; they saw themselves as outsiders and thought that whatever happened in that community did not concern them, and therefore their views were not as important as those who have lived in the area for a long time.

"...another issue is...to do with the transience of the population here. Even though there is a core community that have lived here for many years...a large element of the population don't stay here." – SFE

Engaging certain groups, for example, middle-aged men and young people was a challenge. These groups did not want to attend events. They want to be engaged in a different way, on their own terms, which was not possible within the programme:

"One group that is very difficult to get them to participate is the middle aged men...it's difficult. If you go down to the pub and you have a chat with them, they've got loads of ideas but if you put them in a more formal environment, they don't want to be part of it. Young people will participate under the right circumstances...if it's something that's affecting them now, they will participate." – EAH

On the other hand, the community events engaged a lot of 'usual suspects' who always participate in every community activity that comes up. Therefore, to ensure a more diverse spectrum of residents representing the community was a challenging issue.

"...you tend to find that you get the same people who are involved. It's the same people who become the community activists." - LME

Some respondents said that in the age of electronic communications, people were used to communicating via 'Facebook' and 'twitter' and encouraging them to have physical contact and meet face-to-face was difficult

"...people do most of their communicating via 'Facebook' or internet or text messaging and so on, and we really need to ensure that people keep on meeting each other face-to-face." – SFE

Some residents were sceptical about the CEP; others were frustrated when they realised that some of the promises made would not be fulfilled. Some were disappointed not to get enough feedback on the issues they identified as community problems; while some were upset about other projects happening in the area and turned their anger on the WL programme.

"One of the barriers...is the scepticism that people have." - DRS

"Frustration…They get tired of being consulted…some people would say they would like to walk more, some people would say that they want to ride horses. But unless you communicate back saying that it is not viable to ride horses, then there is a sense of emptiness; they don't know what is going to come next." – EAH

"The challenges to community engagement in this area, up until now have been around people feeling let down." – SDH

Some people were tired of being continuously asked what they wanted, especially when they did not get what they had asked for. So the challenge for the local CVOs was to convince people that WL was different and worth trusting.

"…they got continually consulted and then sometimes or maybe a lot of the times …they discover that their opinions weren't listened to…I think the residents were slightly disillusioned; constantly being consulted…So, over-consultation; that was one of the issues." – LME

"…'consultation fatigue' is a real, real problem…people are very cynical about being consulted about things because they feel that no matter what they say, things aren't going to happen." – SFE

Some noted a general apathy and unwillingness to be involved in the community life, particularly when the issues discussed did not concern the residents and their families directly:

"They don't want to know what's going on; unless it's affecting them directly or affecting their children directly, they don't want to get involved." – EAH

Socio-economic and cultural differences were also noted. Addressing the needs of a diverse community was a challenge. For example, in some communities, women could participate in certain activities only when men were not around; in some areas women could not talk openly about their problems.

"And I suppose in certain sections of the community, particularly when it comes to physical fitness and exercise, exercise for women; ensuring that it's in a certain environment, it's an all-female environment." - LME

Another example of cultural differences was the fact that in some cultures, particularly in Africa, it was required that a form of monetary compensation is paid for time and participation. This presented a challenge for engagement events which relied heavily on volunteering and community involvement being seen as a rewarding activity for which the participants required no monetary payment:

> *"I was talking to Somalis the other day and one of the things that they said is that in their culture, if you work with somebody you must get paid so volunteering is not [appreciated]" – DRS*

Low socio-economic status of the community residents and subsequent lack of confidence also presented a challenge to the engagement. Many people did not feel confident enough to express their opinions or felt that what they have to say was not important or would not be heard.

> *"…some of those people…feel inadequate to bring their ideas forward." – EAH*

Other issues associated with low incomes included long working hours and other priorities which prevented people from getting engaged.

> *"…the way people prioritize things…If you're living on the 14th floor with three kids on benefit...ha! Your main focus is on making ends meet, surviving." – SFE*

Some respondents mentioned differences in the communities they engaged. This is how one community organisation explained why people of White backgrounds engage more with their communities than people of Black backgrounds. They thought that people of White backgrounds were more likely to be economically secured and could therefore afford time to participate in community activities while people of Black backgrounds could not afford such time.

> *"Not a lot of Black people attend; it's more white people...some of it might be economics where you find more White people have got the economics, their economic circumstances are much better." – DRS*

Other challenges identified by the participants included the recruitment and retention of volunteers; and talking about health was an issue because for many residents, breaking down established unhealthy behaviours and reinforcing the healthy ones was difficult.

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8.4.4. How to Overcome Challenges

The community organisations interviewed suggested a few ways of overcoming barriers and challenges. These included better timing of the community activities; provision of childcare; provision of interpreters; different focus groups for different groups of residents; having a more meaningful consultation; treating the people with respect and listening to what they say; and being flexible.

> *"...classic things like the timings of consultations, providing child care, providing people to interpret or translate, having different focus groups where people would feel comfortable." – SFE*

> *"...it's whether they feel listened to and whether it's meaningful; whether they believe in the ideas…you've got to use the structures that are there to make it work." – VEB*

The community organisations were also asked about the ways to successfully engage the community. They reported a number of methods which they thought were effective to get information across to the community members or engage them in the community activities (figure 8.8).

Figure 8.8 – Ways of engaging with communities

Ways of Engaging with the Communities
- Community leaders and organisations
- Community forum, meeting and networks
- Resident-led board/committee
- Local activity groups, e.g. after-school clubs, youth clubs
- Road shows and festivals
- Community information shop
- Use of interpreters
- Door-knocking
- Newsletters and questionnaires
- Text messages and emails
- Face-to-face
- Telephone

Thus, many community organisations reported that they used trusted and respected community leaders to pass on information to the residents.

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Sometimes they also used organisations which represented specific population groups such as older people, tenancy representatives, ethnic groups and leisure interest groups. It was argued that since the members of such organisations were already engaged in community activities in one form or another, it was easier to get them on board, particularly if their local organisation endorsed or recommended the event to them.

> *"...community leaders; iconic figures [who] lots of the users actually know, respect and trust" – DRS*

The respondents explained that some community organisations had resident-led boards or committees where the residents had a say; and such meetings were a good way to discuss the topics that affected the community. Another way of involving people was through existing institutions like schools, after-school clubs and activity clubs. These groups gave an added advantage of engaging children and families.

Festivals and road shows were also noted. These were seen as particularly useful ways because such events provided entertainment and fun, and the residents could engage with the community activities without making any extra effort.

Some community organisations said that they had front shops offices where they provided information to the residents and where residents could come to discuss issues of concern. In such cases, the names and contact details of the residents were taken and logged into the community organisation's database so that these individuals could be contacted directly for future community engagement events.

Personal contacts with the residents through door-knocking, text messages, emails and telephone calls were reported to be particularly successful because of the personal touch associated with such means of communication. The residents were said to feel more obliged to attend the community activities because they were invited personally:

> *"...see them face-to-face...it shows that you care because you've actually made the efforts to go over." – LME*

The importance of using interpreters where necessary was stressed, especially when there are known groups of residents who do not speak English as their first language.

> "…we usually go out with an interpreter that allows us to communicate with them." – EAH

> "we work quite closely with one of the Somali organisations on the estate and there can be the language barrier there…so…we use members of the Somali organisation to actually filter the message through to their users." – LME

When newsletters are used, it is important that they are delivered at regular intervals so that the residents become familiar with them and connect with them as a means of obtaining information about what is going on in their community. These newsletters can also help in obtaining information from the residents through surveys and questionnaires enclosed in the newsletter.

All the respondents stressed that community organisations did not depend on just one form of communication with the community residents; they all used as many as possible.

8.5. Impact of Well London CEP

There was a general view that the effects of the CEP were not significant. The process happened at the time when there were many other important issues happening locally, nationally and globally. The respondents said they were more concerned with other things such as economic uncertainties, recession, high unemployment rates, terrorism threats, political tensions, and natural disasters. These issues prevailed were more important for community organisations and local residents than healthy eating, physical activity or green open spaces.

> "I mean, the real issues I think are far, far bigger than anything Well London can ever handle because you are talking about poverty, globalism..." – SFE

However, some effects of the CEP were noted by the study participants.

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8.5.1. Impact on the Communities

The main impact of the CEP identified by both the co-hosts and CAW participants was that many residents moved from siloed communities where the individuals and organisations were not joined-up, to more cohesive communities with better social networks and knowledge of one another (figure 8.9).

Figure 8.9 – Impact of CEP on communities

Impact of CEP on communities
➢ Cohesive and empowered communities
➢ Improved health and wellbeing of residents
➢ Improved services in the community
➢ Community cohesion and social networking
➢ Improved access to services in the community
➢ Improved health and wellbeing of residents
➢ Skills acquisition and training
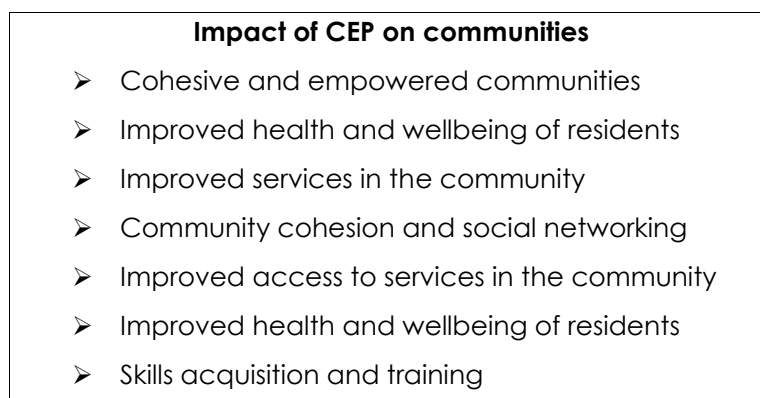
Here are some of the comments made by the CAW participants regarding the impact of the CEP on the communities:

- *"It [CEP] has the potential to promote community cohesion."*

- *"[It is] giving the community a voice and hopefully allowing the projects to be sustainable in the future."*

- *"... [it] re-engaged residents of the community to develop healthy and safe habits and environment."*

- *"...[It] can improve lots of aspects, e.g. health, mental wellbeing, community spirit."*

- *"[CEP] bring all ages, races and cultures together through the process to a better community."*

- *"[It is] empowering them to have an influence over their services."*

- *"Linking with housing regeneration and economic regeneration teams, police."*

The co-hosts pointed out that the new friendships and networks developed within the community as a result of the CEP had a potential to bring different

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sections of the community together. Specific components of the process such as informal chats and food made interactions between different sections of the community easier. Such relationships helped to unify the communities in a better way. People who had lived in the communities for years but did not know each other started saying hello; and this brought warmth and trust into the community; it confronted fear and scepticism and helped people to better know and understand each other.

> *"...I think it's bringing people together because...one person was saying to me on Saturday, 'the neighbour across the road, she always passes and never says hello but now she says hello because of Well London.'" – DRS*

Another key impact identified was improved access to local services. Before the CEP, there were misconceptions about certain services, including uncertainties about costs and types of services available. The CEP provided information about what services were available, what services could be accessed at no cost or at a concessional rate; what special arrangements were available for certain groups such as female-only gym and swimming sessions. All these impacted on the residents' willingness to use the services.

The CEP allowed residents to say what they wanted from their local services and what barriers prevented them from accessing these services. As a result, special arrangements with the local services were made; and many people who could not ordinarily access these services were given an opportunity to do so. For instance, in Southwark, an arrangement was made with the local leisure centre to allow volunteers to have free access to the centre. These volunteers went out into the community to tell the residents what was available and which population groups could access it at a discounted rate.

The residents also received information about healthy eating, physical activity and mental wellbeing. Some respondents said that they hoped that the little behaviour changes encouraged during the engagement process would lead to more sustainable healthier lifestyles in the long term.

> *"...encouraging people to exercise, to do arts, to run food co-ops and things like that, it's great. If that can work and be embedded, it will have made a real difference to people." – SFE*

The CEP also helped boost residents' self-esteem, and possibly prepared some for future employment. The benefit of improved self-esteem was particularly important for residents with mental health problems because they were no longer isolated and they gained confidence through being useful in the community.

> *"…they've gained confidence…by gaining that confidence they know that they are able to do something and maybe that will enhance their opportunities to get a job later on." – LME*

> *"…for example, [those] who are unemployed and the carers or have got long term illness; I think you are going to dramatically increase their self-esteem, which I think is going to have a big impact on their mental health and depression…I think that's going to lift people up." – SDH*

The CEP helped to identify community volunteers who were expected to engage local residents through signposting to services and providing information which again built social networks and boosted individual confidence.

8.5.2. Impact on Community Organisations and Local Stakeholders

The first type of impact identified by a number of co-hosts was giving them a first-hand experience of different types of community engagement approaches. The respondents said that they had got a better understanding of the community and how to work better with the local residents. The CEP also changed organisational thinking about partnership working, staff development and volunteering (figure 8.10).

Figure 8.10 – Impact of CEP on co-host organisations

Impact of CEP on co-host organisations
➢ Influence on organisational thinking on community engagement
o   New engagement approaches
o   Partnership working in community development
➢ Better understanding of the community
➢ Staff development
➢ New pool of volunteers in the community to work with
➢ Reinforced role of organisation in the community
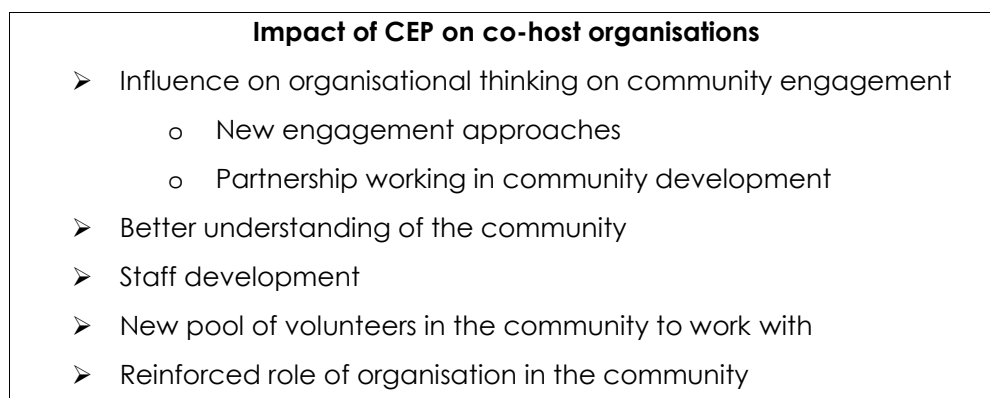
The CEP methods used during the cafés and CAWs greatly influenced the co-host organisations. Many of them said that they would apply these methods for their engagement purposes in the future.

> *"We actually picked up on some of the aspects…for our own community engagement such as like the community cafe, it's a wonderful idea." – EAH*

> *"…we are probably going to use something like the community engagement cafes." – DRS*

Multi-organisational partnership was also important. Prior to the cafés, most community organisations had small remits and usually worked alone. Working in the WL programme, they realised the advantages of having other organisations on board, each contributing its own expertise but having similar goals and objectives.

The engagement process also helped the community organisations to understand the communities better. This new understanding would help them to approach community engagement in a different way and address the existing frustrations and scepticisms. Many said that they had realised the importance of clear communication and transparency in working with the communities.

> *"Some of the information that actually came out of that process, some of their ideas, some of their thoughts, some of their opinions; seeing where they are coming from more and why they may be slightly sceptical about a variety of consultation processes." – LME*

Some noted staff development within their organisations; some staff engaged in new roles, some developed the new organisational themes. There were also opportunities for training through seminars and workshops. For example, the University of East London organised a seminar about the World Café method and gave an opportunity to acquire facilitation skills. There were opportunities for visits to different places such as other successful community development projects.

> *"...two or three of my team, they are interested in pursuing a career in health promotion and they see this as an ideal opportunity to get themselves on the stepping stone." – DRS*

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The CEP generated an invaluable pool of new volunteers for the community organisations. This pool helped these organisations to keep low overhead costs and be closer to local residents.

"We are now starting to engage people on a more, smarter way of working...now we are starting to use volunteers to be able to establish that link between residents and resident groups." – EAH

The community organisations also expanded their network of contacts through the CEP. Many of them included the names and contact details of the residents who attended the engagement activities onto their databases:

"...we were able to build relationships with different people. And we have now got a handful of different people who are getting more involved in what we do." – LME

Another important impact of the CEP for the local organisations was that it reinforced their presence and status in the community.

"...for our organisation...it helped reinforce...our role as that 'harbour and anchor' organisation in the area." – SFE

The CAW participants said that their organisations were able to network with other organisations in the LSOAs; this was beneficial because they were able to share information and resources with other stakeholders. Some said that they had already started talking with other organisations about possible joint projects. Many thought that they would be able to extend their projects through new funding coming from WL. Some said that they were able to raise awareness about their organisations and let people know what they were doing. They hoped that this would improve their reach into the community and get more people to participate in their activities.

8.5.3. Impact on the Well London Interventions

The co-hosts said that the projects delivered reflected some of the needs identified at the consultation stage. For example, people wanted to get together in the community, gain new skills, get healthier and be more physically active and creative, and the projects delivered these (figure 8.11).

Figure 8.11 – Impact of CEP on design and delivery of projects

Impact of CEP on design and delivery of projects

➢ Intergenerational and intercultural activities

➢ Creative activities

➢ Skills acquisition

➢ Level of participation in projects

➢ Filling gaps versus addressing needs

The CEP made projects more intergenerational and intercultural because the residents said they wanted such activities. They also wanted the activities to be fun, and the WL programme expanded their pool of entertaining and celebratory ideas. People wanted to get to know their neighbours, their cultures and their foods, and the WL projects provided opportunities for festivals, fun days, cooking classes and arts projects.

> *"I think that's very much shaped by what came out of the consultation." – SFE*

> *"…dealing with the main issues on the estate…that did come up at the consultation…people not knowing their neighbours…it broke down some of those barriers and… get to talk to different people." – LME*

The projects did address the issues raised by the residents, particularly with regards to eating and physical activity.

The consultation also identified a need for skills acquisition and training, especially for young people and those unemployed. As a result, skills acquisition and training was part of many of WL projects. Residents learnt to grow and cook their own food, buy healthy alternatives to their usual food items, do arts, and engage in community volunteering.

> *"...that's another thing that came out of the consultation; people wanting to get more training. And one of the benefits from this project is that you will be up-skilled." – LME*

Some co-hosts however argued that the consultation had very little or no impact on the projects. Some argued that the number of people who participated in the consultations and subsequent activities was only a fraction of those living in the area and therefore the impact on the community as a whole was marginal.

"I think there are about 2000 plus people that live in the…area, now I reckon that during the course there were six in our training; there were probably about 15 to 20 at art and mosaic and there were about 10 people with and 'eat and grow'; so if you add all that together, that's about 26 plus another 10; 36 out of 2000. So the answer to your question is probably, well, are those projects really meeting the needs of all or just meets the needs of a small amount of people?" – DRS

There was also an issue of whether WL projects did indeed address the needs of the residents or simply filled in the gap in their knowledge of existing services. For example in Hackney, the residents asked for walking groups. However walking groups already existed in the area but people were either not aware of these groups or the groups did not have sufficient funds to ensure adequate coverage.

"I won't say that they address the needs; they filled a gap. There was a gap because the people that were doing the walks before had identified that they wanted to do more walks but because they didn't have the funding, they weren't able to do it. Well London came along and said we are going to do more walks so from that perspective, they came in and they filled a gap but they did not address the need." – EAH

In many cases where the WL projects were delivered, the services already existed and the local service deliverers were not happy that WL was duplicating what they were doing.

"…one of Well London's priorities and statements were that they would not duplicate work that's already in the area, and that has happened. They said they were just bringing in capacity and what happened is that they brought in external agencies that they were already working with to do the work." – EAH

The co-hosts also recognised that many WL projects had been already designed prior to the consultation. What they would have wanted was for WL to make this clear to the community from the start and say that they could have a choice of the already designed projects rather than making them think they were the ones designing the projects.

Chapter 9 – Results:

Community Engagement Process and its Impact – Well London Alliance Partner Organisations' Perspectives

9.1. Introduction

This chapter explores the perspectives of the organisations in the Well London (WL) alliance organisations concerning the WL community engagement process (CEP). The data presented here has been collected through an open-ended evaluation survey following the phase one CEP, and qualitative interviews.

This chapter examines what the delivery partners felt was good about the process, what could be improved, and which lessons have been learnt. The chapter also examines some incentives and challenges for the WL partners' participation in the community engagement events, and their perception of the impact of the CEP on the communities and their own organisations.

9.2. Characteristics of Participant Organisations

Seven organisations made up the WL alliance partnership. These organisations had different types of expertise in health promotion including community work, physical activity, mental health and wellbeing, arts and culture, healthy food access, healthy green spaces, and strategic planning. More details of these organisations can be found in chapter four and appendix II.

Six of the seven partner organisations responded to the evaluation survey following the phase-one CEP. SLAM did not complete the questionnaire, indicating that their views were presented by the co-host community organisation that coordinated the WL programme in the same area as SLAM. The evaluation survey data was supplemented by the researcher's participation in three evaluation meetings following the phase-one events.

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Fifteen individuals from the seven WL alliance organisations participated in the in-depth interviews. These individuals held key strategic decision-making positions in the organisations, or were involved in the fieldwork and implementation of the programme at grass-root level.

9.3. Perceptions of the Well London CEP

The survey and interview data suggest that overall the delivery partners were positive about the CEP and regarded it as effective and useful, particularly considering the limited timescale and resources available. It was felt that the process enabled the organisations to better understand the target areas and to gain insights into the communities' needs and concerns. This was extremely helpful in planning the projects tailored to the area needs.

The CEP itself was perceived as interesting and engaging; it was seen as a useful and meaningful way of engaging the communities and gathering information in an informal but systematic way. However, there were problems with the engagement methodology, timescale and unmet residents' expectations. The partners felt that the CEP had both positive and negative aspects and that it achieved some of its expected objectives but also produced some undesirable outcomes of frustration and apathy due to unmet expectations and needs.

9.4. What was good about the CEP?

The delivery partners identified a number of benefits of the engagement events for both the communities and the WL alliance itself; figure 9.1 summarises these key points.

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Figure 9.1 – What was good about the CEP?

What was good about the CEP?
➢ Getting to know communities and local stakeholders better
➢ Identifying potential local delivery organisations
➢ Networking with other WL partners
➢ Ability to gather information from the communities
➢ Promotion of community wellbeing through building relationships and networks
➢ Innovative engagement approaches (World Cafe & Appreciative Enquiry Approach)
➢ Marketing and recruitment for participants using street artists
➢ Community cafe exhibition and space design
➢ The cafe and workshop facilitator

The first important issue identified by the respondents was the relaxed environment of the events which made it easy to meet the local residents and stakeholders, and to get to know them better through informal discussions and interactions. Furthermore, the cafés helped to identify the local stakeholders who became the project partners and helped to deliver project interventions in the community. The engagement events also provided a good opportunity for the WL alliance partners to meet one another in an informal setting and to identify themselves as one WL entity rather than individual organisations. This, they thought, helped them create a sense of togetherness and mutual respect

Several partners thought that the information gathered from the CEP was essential to tailoring the design and delivery of the projects to meet the needs of the local residents. The qualitative interviews respondents recognised the CEP as a fundamental basis for the delivery of the WL programme and the understanding of the needs of the communities they anticipated working with, as one respondent explained:

> *"In terms of Well London, I would say it's critical…I don't think we could have done Well London had we not gone through the community engagement process.' – MHY*

Many partners pointed out that the CEP was a transformational process which provided a new way of working and engaging with communities. Many said the CEP was an opportunity for them to experience a new approach to community engagement first-hand and to get some learning to be used in future community engagement initiatives.

> "I think it was a very innovative model...quite stimulating and innovative approach...I liked the idea of community cafes and I thought appreciative enquiry workshops also worked...very useful." – GBL

> "...the cafes...were outstanding as a community engagement tool...I had never seen community engagement done in this way; it's quite unique...I thought that was quite a good model and I will always take that with me as a model.' – SPY

The World Café model used in the community cafés was identified as a successful and innovative way of engagement; it allowed information to be gathered in a comfortable, relaxed and informal setting:

> "I think there is something there about the information that you can glean through those informal processes that perhaps you can't necessarily get otherwise." – KTA

The appreciative enquiry process used in the CAWs was also regarded as a useful and interesting tool because the focus was on the strengths and opportunities present within the communities rather than the problems being addressed:

> "...the appreciative enquiry is all about what's worked and how we can make things work." – MHY

The CEP was thought to be highly beneficial to the local residents as it helped them socialise with their neighbours and stakeholder organisations; and gave an opportunity to influence the design and delivery of the projects. The process was thought to be a very enjoyable experience which gave people the opportunity to explore issues they faced from personal perspectives, and to voice their concerns:

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"…people that came along…had a very positive experience…it was a chance to talk about local issues and meet other people and get to know your neighbours in a positive way." – APL

The WL partners noted that the ambience of the community café space, the informative exhibitions and the detailed design of the CEP worked together to make the engagement process effective. All the respondents said that the café exhibition was a good, supportive and informative tool for the event. Many noted the impact of the exhibitions and the interactive tools on the high levels of engagement and interactions during the CEP.

Further, the skills and expertise of the facilitator were also regarded as exceptionally high. The facilitator was thought to be confident and experienced to hold the attention of the participants at all times; at the same time she was flexible enough to be able to change the agenda to fit the needs of the audience and the requirement of the setting. Both survey and qualitative interview respondents strongly linked the skills of the facilitator to the success of the engagement events.

The involvement of street artists, clowns and balloonists was an important marketing and recruitment strategy which was particularly effective on the day of the community events.

9.5. What could be improved?

Although there was a general agreement that the CEP was a positive and interesting experience, a number of possible improvements were identified (Figure 9.2).

Figure 9.2 – What could be improved?

What could be improved?

➢ Better analysis of information collected

➢ Better mapping of local services

➢ More appropriate timescales

➢ Improved links between CAWs and PIMs

➢ More effective marketing

➢ Better management of expectations

➢ Flexibility of the process

➢ Choice of co-hosts

➢ Improved communication

➢ Improved team/partnership working

➢ More efficient allocation of resources and responsibilities

➢ Integration of project planning and management

The key criticism raised by the survey participants related to the analysis of the information collected through the CEP, the mapping exercise and desk-research preceding the engagement, the timescale of the events, and the marketing strategies.

The alliance partners thought more relevant information could be collected and analysed from the process and through the desk-based research. They found that some information from the mapping process was either not entirely accurate or out-of-date and did not reflect the true area picture; the mapping exercise was referred to as a "*blunt instrument".* The data collected through the CEP was not analysed in a way that could help the detailed design of the interventions. The outcome of the analysis was said to be a cursory and crude ten-point summary of community priorities rather than an in-depth exploration and explanation of community needs. The analysis of the information gathered from the communities did not address wider issues underlying communities' health concerns. Some respondents argued that the limited analytical approach led to an under-estimation of the complexities these communities faced; and resulted in the development of over-simplistic solutions. They also

questioned the quality of the outputs of the engagement process and said that the insights gained were inadequate, superficial and not ground-breaking. Therefore, the process' contribution to knowledge and project design was debatable:

> 'I think we were disappointed…It was just a…kind of superficial stab at some statistical stuff and some other stuff that was pretty well common knowledge." – SCS

Another point mentioned by the survey respondents was the unrealistic timescale of the CEP which did not allow for any detailed reflection or feedback. It was recognised that the process was rushed due to the time deadlines which compromised the depth and the quality of the engagement. It was also mentioned that a longer period of time was needed between the CAWs and the design of the area-tailored interventions to allow for a better community focus. Similarly, the PIMs had to be better planned to allow the local residents to have a stronger voice with regards to the WL interventions.

Several respondents pointed out that there were limited opportunities for the communities' feedback on the interventions designed and the attendance of the events by the residents varied considerably across boroughs and across events. Even where the attendance was good, it was not necessarily representative of all sections of the community especially the young people. Qualitative interview participants also noted the attendance of the events and that the audience was inconsistent in both the numbers and composition of attendees.

> "…in some boroughs…in terms of who engaged…not very many people in the SOA were part of that process; not many of the key stakeholders were involved…So, you can go back to that community even a month later and say, "Hey, you guys said you wanted us to focus on old people", and they'll say, "Who said that?"." – SPY

Poor participation and attendance recorded in some areas questioned the generalisability and quality of the information gathered through the engagement:

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"I know in Brent…nobody turned up in the community engagement. So, whilst they were able to write a really nice report, it was based on limited responses to the community engagement" – SPY

Some partners felt that the contributions of those who attended the events could be strengthened by involving them at a very early stage through a comprehensive co-production approach; that is, the engagement process itself had to be designed with the involvement of communities and their representatives.

Some respondents noted that they relied heavily on the co-host organisations to market the events whereas they should have used a variety of avenues, agencies and approaches to raise awareness about the CEP.

One of the most important aspects of the CEP that could be improved mentioned by the interview participants was managing the expectations raised in the communities around the WL programme. It was argued that the CEP created a lot of enthusiasm within the communities; however, the time of intense engagement was followed by a period of quietness when nothing happened and the residents were understandably disappointed and frustrated. Some partners believed that this relatively long period between the expressed commitment and the actual projects was detrimental for the programme success, particularly in the first few months of its implementation. Some partners perceived that the engagement process raised false expectations because there was no clear understanding of what was feasible or achievable under the WL programme. There were no parameters or limits set to what the WL programme could do and this was reflected in the ambiguous and broad café questions. As a result, the communities were disappointed at the PIM stage when they realised that they were not going to get the "silver bullet" which would solve all their problems. The partners suggested that the process would have been more acceptable if the projects were designed from scratch rather than from a prescribed list of intervention.

"So I suspect that what happened in the community engagement approach was that we may have frustrated and irritated as many people as we did inspire and excite, if not more." – MHY

Some partners mentioned the monetary expectations of local stakeholders who believed that a certain amount of money would go directly to them or their communities. All partners said that they experienced backlashes as a result of the false communities' expectations of the WL programme, and many had been asked about the *"pot of money"* they had been promised. These expectations had not materialised because the money had gone to the communities indirectly through the delivery of projects rather than the award of monetary grants.

> *"…so people were expecting £100,000 but there's no way, they can't see it. Or they expect that they would have more control of how it was spent and actually, they don't." – TCS*

Some respondents believed that many participants were left aside after the engagement events and their views and suggestions were not followed up. This created an impression that their involvement was not valued. A series of falsely created and poorly managed expectations had an undermining effect on the reputation of the WL programme and individual organisations of the alliance.

> *"I feel that a lot of people have very high expectations of what the projects were going to deliver and the scope of their influence upon how hundreds of thousands of pounds was going to be spent…that has proved to be quite damaging…for…the reputation of Well London partners." – GBL*

The interview participants also identified the problem of adapting the process to individual areas and their needs. The CEP was delivered as an inflexible process in all target areas. Some partners thought that whereas the model of the community engagement itself was appropriate, it should have been customised for each target LSOA because the areas had different community engagement histories and were at different stages of community development; they therefore had different expectations of the process.

The choice of a co-host organisation was a problem in some areas. Several WL alliance partners commented that they would want to have spent more time choosing their co-hosts because their choices were not always adequate and negatively affected several aspects of the engagement. Some respondents noted variations in the experience and capacities of the co-host organisations involved. They noted that the engagement process was more successful when

it was led by a co-host that was well connected to the community, for instance in Ealing and Westminster:

> "But the community cafe was very successful in Westminster…was attended by over a hundred people; lots of families, lots of young people. And that is…the direct result of the co-host because they are totally integrated into their community, they are very well connected with residents as well as community organisations; and they worked really hard. They always have a presence on the street; people know who they are. They have a visible location within their community which lots of people access and use." – KTA

The partners said it would have been useful to have had guidelines for appointing the co-hosts which would reflect the diversity of the role and responsibilities. They suggested that one of the criteria for appointment should be the level of activity and community reach of the co-host organisations.

> "…the community engagement process is heavily dependent on finding and identifying a good co-host. And I think that if you identify the wrong co-host…the actual reach that you can have as an outsider coming into an area and trying to invite local residents along to events, is going to have no impact whatsoever...I would say that was a fundamental thing to get right. If you don't get that right, then you end up further down the line having loads of problems." – KTA

A number of partners noted the complexity of the process and felt that it was laborious, time-consuming and inefficient:

> "It's all been so unbelievably time consuming… it is very labour-intensive…the effort was phenomenal; the reward at the end of it is just squirt." – SCS

Furthermore, the process was delivered in 20 communities in a short space of time which increased the strain on both human and time resources.

Communication was another very important aspect of the CEP that could be improved. The interview participants referred to the communication between the WL partners and the communities, as well as communication within the WL alliance group. Some respondents noted a need for clear and consistent language and terms, particularly when communicating with communities. It was argued that ambiguous and careless language may have led to the

misunderstandings and wrong expectations among the residents and local organisations representing them.

> "...sometimes when people don't pick up on the same kind of language...there are miscommunications that happen as a result of that." – GBL

With regards to the internal communications within the WL alliance, some respondents argued that there was a need to build a team spirit within the alliance from the start; to create an atmosphere where there is trust and good understanding of each other's priorities. Many interviewees agreed that there were disconnections in the lines of communication at the various levels of the WL partnership. One reason offered by the interviewees was management of the programme within the organisational hierarchies. Thus, the senior staff of the partner organisations involved in the original programme bid thoroughly understood the programme strategies and what they were trying to achieve. Junior colleagues and newly-appointed staff were handed over the programme implementation. They however did not fully appreciate the scope and the focus of the programme nor did they have a decision-making authority to make changes in response to the programme needs. Some respondents mentioned that the senior managers within the partnership had their own communication channels which were different from those used by the project managers and fieldworkers, which further contributed to the disintegration and fragmentation within the partnership:

> "...the senior partners have...gone on to other things, but they are the ones that are keepers of the knowledge. They have that history...You've got all these new people who've come in...And you've got this great huge trust gap; you've got a great huge information gap." – SCS

Some partners noted a power struggle within the alliance with different organisations trying to push their own agendas:

> "...it's a bit like family, isn't it? ...who shouts the loudest gets the most attention...And people are fighting all the time, trying to get their voice heard, their project heard." – SCS

Another issue was the allocation of resources and responsibilities within the programme. Several partners suggested that the borough coordination role which each alliance organisation (except LHC) had to perform was an extra

burden which was not supported by any specifically allocated time or resources, and placed a strain on the delivery of the projects.

"The borough coordination role is foisted unto the partners without any additional resource being made available to support that activity and this has actually been a complex, time-consuming process. And that has withdrawn further the available resource within the organisations to deliver." – ARU

Some suggested that more project planning and management skills should have been employed for the WL programme, especially for the borough coordination role. The interviewees commented that although they had employed project managers, they performed largely community development fieldwork and little project management. As a result, the allocation of resources and time between the activities was not always appropriate. For instance, there was insufficient time allocated to the planning of the CEP and the process was rushed through its different stages. In the same way, the time and resources needed for specific project activities were not always accurately estimated and many organisations were overworked and under-resourced. Many interviewees believed that a stronger programme management capacity within the WL would have resulted in better project planning and more efficient resource allocation.

"The way and how Well London is structured, you would maybe need a good 18 months development time before anything goes out live in the communities; to build, set up your systems, your templates, and your meeting structures..." – SPY

Some respondents talked particularly about the CAWs. Similar to the community cafés, they felt that the CAWs raised a number of expectations beyond what could be achieved within the programmes and as a result, the focus of engagement was too broad. The appreciative enquiry approach reportedly worked when there was a good mix of residents, local stakeholders and strategic stakeholders. But this was not always the case especially when the timing of the workshop was poorly planned.

9.6. Lessons Learnt from the Well London CEP

First, all the interviewees agreed that the review of lessons learnt from the first phase of community engagement was extremely useful. The evaluation helped to identify some of the problems incurred in the first phase and minimise their impact on further engagement events. The partners reiterated the lesson of managing expectations and providing clear communication. The interview accounts suggest several other lessons reported by the alliance partners (figure 9.3).

<u>Figure 9.3 – Lessons learnt</u>

Lessons Learnt

The need for and importance of:

➢ Managing expectations

➢ Clear purpose for community engagement and how it fits into the overall programme

➢ Realistic timescales and time to build relationships

➢ Flexibility and adaptability

➢ Sound knowledge of the diversities of the communities

➢ Clarity and understanding about project management procedures

➢ Shared understanding, goals and outcomes

➢ Common definitions and terms

➢ Local area coordinator

➢ Building local organisational capacity and finding appropriate local partners

The key lesson was the need for explicit and clear communication of the programme's commissioning and delivery processes to the local residents and stakeholders. Such communication would have helped the communities to better understand the complexities of the programme, funding, management and delivery; and would have mitigated the impact of false expectations when certain things were promised but could not be delivered in the way and manner they were originally presented.

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"We should have managed expectations a bit more and I think we should have been very realistic in saying, 'this is a complex programme, it might take us a while to develop projects and also we've agreed these things with the Big Lottery, they are non-negotiable over things like the commissioning and I'm sorry we don't have much funding actually; it's not a lot of money but we'll be using it in a very effective way, integrated way to get the maximum impact.'" – APL

A thorough thinking around the practicalities of the programme commissioning and delivery was put off till the last minute by which time it had to be rushed along without proper understanding of how it would work out. Alliance partner staff said that they had to find out and learn about the commissioning and delivery processes at the time they were to commission or deliver projects. This led to a lot of frustration and stress for the organisations' staff.

"But certainly in the future, if I worked on any other programme, I'm sure I speak for everyone; we would first of all make sure there was complete clarity over some of these tricky issues, that we were all singing from the same song book, and that we didn't raise unnecessary expectations...." – APL

Another important lesson learnt was the need to clearly state the reasons for the CEP and how it fitted into the overall programme. It was argued that such shared understanding of the process could have increased community involvement and the feeling that they truly contributed to the intervention design. It would also give the communities a yardstick to measure the success of the programme by, and serve as a tool for the organisations to evaluate the success of their projects.

"…one of the key issues is that community engagement needs to have a very clear purpose...Absolutely clear hand-on-your-heart capacity to say that taking part in this is going to going to make a difference...that it is actually going to have a real influence and impact upon how resources are used within that community, to promote the health and wellbeing of the community downstream." – ARU

Another lesson was the need for a realistic timescale, including the time required to build relationships and partnerships with the communities. The partners felt that the WL CEP had shown once again, the undisputable need for time to make things happen; and that community engagement cannot be rushed or hurried. In the case of the WL CEP, the time between the

cafés/workshops and the design of project interventions was too short; while the period between the intervention agreement and the actual implementation was too long. The partners felt that the reverse time allocation to these programme stages would have been more appropriate and could have helped to promote trust and sustain enthusiasm within the communities.

"I believe it's important to take time to build up the trust and credibility." – GBL

Sufficient time was also needed to get to know the communities and their day-to-day activities and routines. For instance, scheduling community events resulted in poor community recruitment in many areas. Also the ability to be flexible and adaptable to the diverse community needs was seen as main prerequisites of future community events. It was argued that flexibility should be reflected in the way the community events and programmes are planned as it can help remove the barriers. The partners also recognised that the CEP demonstrated the diversity of the communities they worked in, and suggested that it may not be possible to engage with such communities in any one standardised way:

"Even if it is in the same borough, in the same kinds of neighbourhoods, two corners street corners can be completely different. So, it's really hard to say there is a standard approach." – CDG

The WL partners felt that the project management procedure could be improved. A better thought-through model of programme management would have resulted in a clearer documentation of who was doing what, when, how and where. The partners also noted the importance of a shared understanding of goals and outcomes, as well as common definitions and terms.

"...clarifying what we meant by community consultation, community capacity building, community engagement; reached a common understanding." – MHY

"…if I was doing this again, I'd make sure that everyone had a shared level of understanding of some of the key issues." – APL

Another important lesson was the importance of a local area coordinator who could coordinate the programme on the ground. The respondents felt that it was frustrating that nobody had envisaged how the delivery of the interventions would be implemented locally:

> *"I think that nobody really had an idea about how delivering was going to work at the local level, and that was largely an error in the overall design of the programme…the thing that everybody missed was the fact that somebody needed to coordinate the programme at the local level." – ARU*

> *"...the whole thing [should] have been written in [the plan] because you really need a community development worker for each one of those SOAs." – SPY*

A number of partners did eventually employ the local area coordinators. However, it was largely done halfway through the programme.

Similarly, the interviewees noted the importance of an appropriate and effective local co-host who would facilitate the success of the process on the ground. Effective co-hosts were those with the experience in community engagement and strong abilities to reach a large spectrum of residents and stakeholders in the area. The respondents agreed that they were often constrained in their choices of co-host organisations by the limited number and variety of community organisations in the LSOAs. Furthermore, the local co-host organisations did not necessarily have the same understanding and vision as the WL alliance. The lesson learnt was the importance of time and resources in building local organisational capacity and finding appropriate local partners.

9.7. Incentives for and Challenges of CEP

This section looks at how the WL partners perceived the incentives for and barriers to community engagement for both the alliance and the communities; what motivated the communities and the WL partners to participate in CEP; challenges related to the process of engagement, and challenges in working with the communities; and how such challenges could be overcome.

9.7.1. Incentives for Participation

The partners agreed that the issue of material incentives for participation in the CEP was a complex one. There was a question of whether one should incentivise at all; and what form should those incentives take.

> *"I think that incentivising participation is a complex issue." – ARU*

9.7.1.1. Incentives for Communities

The WL partners identified several incentives stimulating communities to take part in community engagement events (Figure 9.4).

Figure 9.4 – Incentives for communities

Incentives for participation (communities)

➢ Obtaining information

➢ Opportunities for training and skills acquisition

➢ Motivation for change

➢ Increase in social network and capital

➢ Excitement and fun

➢ Building relationships

➢ Free food

➢ Childcare facilities

The first key incentive for participation was residents' understanding of why their participation in a community event was important and how their participation can encourage changes in their local environment. An anticipation of a change associated with the engagement, and a wish to be part of the change process helped the residents feel that their ideas and suggestions are valued and that they had an influence over the issues in their community.

Residents were also more likely to take part if the event provided opportunities for training and new skills. It was argued that such new skills could allow people volunteer, and strengthen personal and communication abilities.

The prospect of deriving some form of excitement and fun from a community event was also thought to be an incentive for many residents. The events provided opportunities for making new friends and connecting with neighbours. This helped to increase social networks and social capital.

Two further incentives were of a practical nature. Some respondents believed that the residents were more likely to take part in an engagement event if there were opportunities for free food and childcare facilities. Although these incentives were not the primary motivators for people's participation, they made people's involvement easier.

Many WL partners believed that the social incentives mentioned above were more important motivators for community participation than material incentives such as money or gifts; and the incentive generating collective gain were stronger than the ones of an individual gain nature.

9.7.1.2. Incentives for Well London Partners

This section examines why the WL partners were involved in the CEP. The key incentives for this group of stakeholders are shown in figure 9.5.

Figure 9.5 – Incentives for WL Partners

Incentives for Participation (WL Partners)
- Become familiar with the new approaches to community engagement
- Shared learning opportunities
- Grant income opportunities
- Academic publications

The incentives identified varied among the organisations depending on their primary field of expertise and organisational nature. However, most partners felt that the CEP provided them with an opportunity (like the community voluntary organisations) to test a new practical approach to community engagement through the community café and appreciative enquiry models. It also provided opportunities for shared learning among the partners, and helped them in working collaboratively in the projects they would not normally do together.

The organisations that received financial support to organise the CEP argued that this income was an important incentive because it provided financial support to the organisation and paid for some of the staff involved in the WL programme.

The University of East London as an academic institution felt that the CEP was a good source of data for peer-reviewed publications.

9.7.2. Challenges of CEP

The WL partners identified several challenges in organising and delivering the CEP. Some challenges stemmed from the fact that the programme was a multi-

faceted and complex piece of work (process challenges); others resulted from working in the WL target areas (challenges of community working).

9.7.2.1. Process Challenges

Process challenges were encountered during the planning and delivery of the CEP. These are shown in Figure 9.6.

Figure 9.6 – Process challenges

> **Process challenges**
> ➢ Time constraints
> ➢ Complexity of programme
> ➢ Limited resources
> ➢ Inter-organisational partnership working
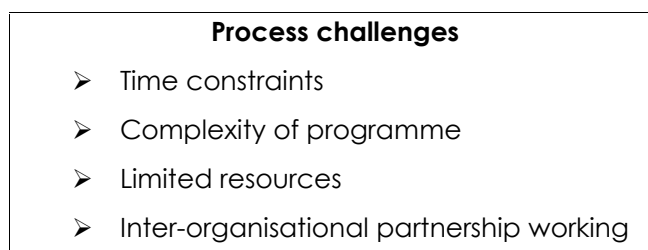
There was a consensus among the partners that there was insufficient time to plan and implement the CEP. The quality of the process and its outputs suffered because there was not enough time to build proper relationships with the local stakeholders and members of the community. This issue was due to the way the programme was commissioned. The CEP was contracted to be delivered in 20 different areas within a very short period of time which did not allow a proper engagement with each area. Furthermore, the amount of work to be done around the CEP had been underestimated, and therefore the process was severely under-resourced in terms of staff and time.

> *"Well, the biggest challenge was just time." – TCS*

> *"...a barrier to the process was...the amount of time and energy that the community engagement took." - MHY*

There were also challenges related to the limited human and financial resources. Some complained that the resources for the CEP were available only to the organisation responsible for it. This limited capacity resulted in the programme staff being over-exerted physically and emotionally:

> *"...we were exhausted; we were physically and mentally exhausted." – KSU*

> *"And limited resources...it's only UEL who has x number of days that they can do that piece of work." – SPY*

Furthermore, some partners felt that there were not enough resources available to make the CEP convincing at the local level. The grant fund appeared to be a large sum of money but by the time it trickled down the various levels of the organisations, what was left for actual community work was not a lot. This was a challenge because one could not convince the residents that what was deliverable was worth their sacrifice in time and effort.

The next important challenge was the magnitude and complexity of the WL programme. The programme had multiple levels, processes, interactions, organisational partners, local partners, unfamiliar terminologies and an unclear picture of what the overall success of the projects would look like. The partners agreed that WL was hugely ambitious in what it aimed to achieve; even the delivery partners found it difficult to comprehend all the programme intentions. The programme became an intimidating giant for many.

> *"The complexity of doing it across 20 boroughs and coordinating with different partners makes it almost like an impossible task…the way the funding was and the way that we are measured and our need to deliver gets in the way of doing the right thing." – TCS*

Multidisciplinary inter-organisational working was an enormous and complex task. All partners reported facing challenges resulting from the multi-organisational structure of the alliance, including numerous local co-hosts, Primary Care Trusts and Local Authorities; each with its own organisational structure, context and goals. Several reasons were given to explain the challenges faced by the alliance (Figure 9.7).

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Causes of challenges of Inter-organisational partnership working in community engagement

➢ Different agendas and priorities

➢ Different organisational modes of operation

➢ Different understanding of community engagement and related terms and activities

➢ No time for team building and development of working relationships before project commencement

➢ Flat hierarchal organisation of the partnership with no organisation having the ultimate authority and leadership

➢ Tensions and issues with co-host organisations

Firstly, the organisations involved had different agendas. Even among the WL partners, the approaches to the programme development, community engagement and delivery of health promotion interventions differed. This organisational diversity was the key organisational challenge from which many other problems stemmed. Many acknowledged that the organisations had little in common other than the need to come together to improve their chances of getting funding for their projects.

> *"...partnerships that come together simply for funding; we know they are fraught with difficulties. And I think essentially this is a partnership that did come together, at least in the first instance, for money." – KTA*

The respondents also noted different organisational cultures and the way organisations operated. Some were rather flexible, operating in creative and resourceful ways; others were more bureaucratic, with a strict set of administrative policies.

> *"...we have seven organisations that make up the Well London Alliance, from completely different sectors, different organisational structures, staff with different levels of experience and knowledge. And it's going to be really difficult to form or have a true partnership." – APL*

> *"...some of the Well London partners...do get a bit irritated with the Arts Council's approach because it is so heavily reliant on bits of paper rather than building up personal or face-to-face relationships. I think that is a fair criticism of us." – KTA*

Another barrier to successful inter-organisation working resulted from the fact that many partners were struggling to survive and although the WL programme was an important part of their operation, long-term organisational priorities took over while the WL implementation was secondary:

> *"Each partner has a schizophrenic role. Firstly, they have their loyalties and their preoccupations with the institutional agenda of the organisation for which they are working…people will always work on their institutional agendas first, and then the partnership second because that's what they are dependent upon for their career progression." – ARU*

> *"…at the end of the day, a lot of these organisations within the partnership, their key focus is their own survival." – KTA*

In some organisations, WL staff members were fully devoted to the programme while in other organisations; they had to work on the programme along with other duties and projects. It was difficult to deliver day-to-day activities with the latter group as meetings and events involving these partners had to be scheduled well in advance. Similarly, while community engagement was a primary function of some organisations in the alliance, for others it was a less important aspect, and therefore the organisations' understanding of the process and commitments to the CEP varied significantly.

> *"There is a difference of understanding between partners, about what is community, what is community development, community capacity building; and as such what is the role of community engagement as part of that process…although we use the same language, what we mean by it is quite different..." – MHY*

A number of partners said that they needed more time to align organisational priorities and agendas and to allow for staff to get their heads around the concepts and the processes used in the programme.

It was also a challenge working as a team within the alliance because there was no time for team building and developing working relationships among the staff. The alliance partnership started off with senior management staff of the alliance organisations; they had authority to make decisions and commit their organisations to a particular course of action. However, as the programme progressed, much of its everyday management was handed over to the

middle level or junior staff, many of whom were new to their organisations and to the WL programme. This handover of programme responsibilities resulted in a) slower decision-making processes as the new staff did not have decision-making capacities or authorities; b) the lack of continuity in programme management as the knowledge of the WL programme remained with the senior management staff who were no longer involved in the programme implementation; c) the lack of a shared sense of purpose or ownership. These problems were further exacerbated by the high turnover of the programme staff and the lack of a planned orientation for the new staff entering the programme:

> *"I think there's been quite high turnover of staff in Well London as well which has made it quite difficult sometimes to keep the consistency." – NDG*

> *"In hindsight, we needed six months to actually recruit staff, get them en-cultured in Well London." – MHY*

Another major challenge was the flat hierarchical organisation of the partnership where no one organisation had the ultimate leadership. This type of partnership looked good on paper but proved to be difficult to manage in practice. The strategic leadership of the London Health Commission proved to be weak in terms of regulations and governance which led to tensions and many unresolved issues amongst the alliance partners.

> *"And taking this collaborative approach where nobody has the ultimate authority, it's difficult for us because it means that things remain unresolved." – KTA*

> *"… frankly, the London Health Commission is very weak leadership." – SCS*

> *"I feel there is failure of leadership within the team…that is not criticism of necessarily individuals but then the process didn't actually clarify the leadership; which meant that there were...there are things that have taken 18 months to resolve that we really needed to have resolved before we started engaging with the communities." – MHY*

The lack of leadership resulted in further tensions between the alliance partners who blamed one another when things went wrong or for slow decision-making, and progress in implementation:

"...when things start to go wrong or things are not progressing as they should, the natural thing for people to do is to find somebody else to blame in this situation. And I think there was a phase of the partnership where people were looking to find other people to blame for things not occurring." – ARU

Tensions also rose when unilateral decisions which affected the whole partnership were made by a single organisation or by one of the partners and the London Health Commission without an input or view of other partners. In some cases, decisions were made by the senior management of the alliance organisations without the engagement of project managers. There were also tensions between the WL alliance and some co-hosts. Some respondents noted that not all co-hosts were entirely dedicated to the WL programme; some were initially committed but lost interest when their expectations were not met; while some co-hosts were not very effective because of their unstable organisational structure.

"The co-host…in xxx, that's been a really tricky organisation to work with…they are now on their fourth member of staff who has been the Well London link person…they've had four people fired by the same person." – SCS

However, some partners were optimistic about the partnership and the direction to which it was headed. They believe that after the initial hiccups, many issues had been resolved and they have better working relationships with their colleagues in the other organisations.

"We are beginning to actually…work together better." – MHY

"They've been quite responsive actually; every time I want to communicate with someone, I've found it very useful." – CDG

9.7.2.2. Challenges in working with communities

Interview respondents reflected on a number of challenges in working with the communities in the WL target areas. These challenges included socio-demographics of the target communities, local regeneration, community consultation history, and access to community assets. Some respondents thought that many community issues in these areas were affected by a set of historical, political and social factors which required substantial analysis and understanding:

"…if you look at the Well London communities, you have to have a really sophisticated over-the-longer-term investment in understanding what some of the environmental issues are, the physical environment, the political issues are, before you can actually start doing anything. And I think that takes years." – SCS

The community-related challenges identified in this study are shown in Figure 9.8.

Figure - 9.8 – Challenges associated with working with communities

Challenges associated with working communities

➢ Barriers to attendance
➢ Local regeneration and politics
➢ Lack of resources
➢ Language barriers
➢ Consultation fatigue
➢ Issues with co-hosts
➢ Fragmentation of communities
➢ Unfulfilled expectations
➢ Mistrust of external agencies
➢ Lack of existing infrastructure
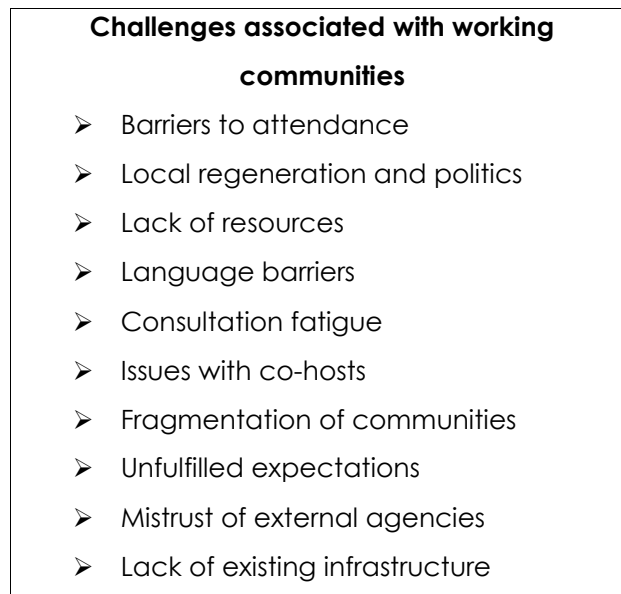
First, the WL partners referred to a set of factors which were specific to these communities and which prevented local people from community participation. These factors included language barriers, mental health issues and isolation, the lack of feeling valuable, and limited knowledge of what is happening in the community. For example, one respondent described their experiences of working with the local residents in Tower Hamlets:

"I'm standing talking to people in Tower Hamlets and realizing that in Tower Hamlets… they don't speak English; not a word of English. They can't even write their names on the name label. So something has to be done initially there about the language issue." – SCS

Structural barriers included inaccessibility or poor knowledge of the venue where the events were organised, and the fear of going out because of crime and anti-social behaviour.

In many areas, there were challenges related to the local regeneration programmes. These local projects were by far more significant to the residents

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than the idea of WL. At many events, they wanted to talk about regeneration problems first. In some areas (Ealing and Hackney), there were uncertainties associated with housing and reallocation of residents. Problems of poor diet and physical activities were of lower importance to these communities.

> *"I think the thing that people could relate to most readily was the changes that were happening on the estate around them…people are very despondent about it….they don't feel that they've been listened to...it had affected people's wellbeing because it is having a massive impact on people." – NDG*

In some areas (Southwark and Lambeth), there were evident effects of the complex local politics. In these areas, the residents were unhappy about the decisions made by the local councils, and the WL programme was seen as an extension of the council, therefore hostilities were transferred to the programme representatives and activities. As a result, it was very difficult to work with these communities and gain their support.

Some respondents believed that the communities they worked with were rather fragmented (same feelings were expressed by the community organisations) and the programme was not seen as an intervention that reflected the needs of the whole population living in that area. In addition, there were segments of the population who felt that those engaged in the community did not represent the whole community but only a small proportion or one group.

> *"I think there are inevitable political issues with the small 'p'. In some communities… those we have engaged with are not necessarily seen as representative of the whole community." – MHY*

There were challenges of community fragmentation by ethnicity, religion, age, and migration status. It was reportedly very difficult to find common interests to engage all groups and bring them together under one programme umbrella. In addition, these areas included individuals and groups that were disenfranchised from the communities and had no previous opportunities to express their opinions. Engagement with such residents was particularly difficult.

> *"...there are people who do not genuinely access services. They are people who generally are difficult to engage with for several reasons; mental health reasons… security issues..." – ARL*

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Some respondents referred to the problems with labelling these communities as "disadvantaged" whereas they did not see themselves as such. Some thought this terminology was diminishing and patronising:

> "…communities that are labelled 'disadvantaged' don't necessarily recognize it themselves. I think…people were actually very happy with the communities they lived but they wanted more services. Whereas we…labelled those as disadvantaged communities and therefore there's a degree of patronization…indices of multiple deprivation...And yet the sense of community in many of those communities is far stronger than places that would not have low IMD." – MHY

Many of these communities had experienced several bouts of consultations before WL and they were tired of going through the same processes over and over again. These communities were labelled as disadvantaged, and they were over-consulted on several regeneration projects happening in the areas. As a result, some residents saw WL as more of the same. Some residents thought also it was another scheme for creating jobs for community engagement workers without any tangible outcomes for the communities themselves. This consultation fatigue led to some level of scepticism and suspicion on the part of the communities who believed that the consultations were a tokenistic venture undertaken by agencies because they were statutorily mandated to consult, and not because it would make any difference for the communities.

> "…fatigue on the part of the community; scepticism; the notion that it is a job-creation scheme for community engagement workers; and the notion that nothing is going to happen at the end of the day." – ARU

Many partners experienced challenges in working with the communities as a result of their choice of particular co-hosts. There were cases where the chosen co-host did not have access to all groups in the community or where there was a tension between the residents and the co-host organisation. The CEP relied on, and was dependent on the co-hosts to reach out to people and engage them on behalf of the WL programme. However, this reach was only as effective as the existing reach the co-host had in the community.

> "The co-host, xxx, apart from the fact they focus on and their priority are older people, they are based like two miles outside of the SOA…They are nowhere

near the SOA ...things have moved on since then and they are no longer involved." – SPY

Frustrations also rose from the fact that some co-hosts did not feel that they were compensated enough for what they were expected to do, and there was no possibility for re-negotiating the funding.

The absence of infrastructure in some communities made the engagement process challenging. For instance in Brent, the partners found that there were no existing groups or structured community forums in the area which they could use as channels to the residents. The limited tenant groups present were not well attended and did not appear to be representative of the LSOA. There was also no community centre in the LSOA or neighbouring localities.

As mentioned earlier, many residents had become disappointed and disillusioned when they realised that they were not going to get the money directly from the programme. This frustrated them and affected their levels of involvement in the programme. Some partners reported that many stopped coming to meetings and were generally unhappy. Some boroughs wanted to pull out of the programme; others lost their initial enthusiasm and simply tolerated the programme's presence.

> *"There is a lot of apathy because people have been either let down or they've just not understood what they were getting involved in." – FAU*

> *"...they've reached this phase where they don't really care anymore; the enthusiasm is gone...Whereas before, they were really passionate and wanted to be a part of what we were doing. – SHY*

> *"...they said they were led to believe...that there was going to be 300,000 pounds made available to the SOA through Well London! And it has subsequently caused a lot of problems...they seem to think it was going to be like a traditional funding stream where there was 300,000 and they could bid into it." – SHY*

Some residents demanded to see the accounts of how their money had been spent. They were disappointed that an external organisation had come into their communities, raised their hopes and then gone ahead to dash those hopes.

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"In Islington, they've held me to account and they've said, "...show us that money. We want a spread sheet showing what's been spent in the area since Well London's started in Islington.'" – SHY

Some respondents therefore noted a lack of trust in external agencies as a key challenge in engaging these communities. Sometimes, this lack of trust was from a general negativity based on media, rather than personal experiences of the agencies.

"There is always hostility to external organisations coming in and imposing things" – NDG

Some also pointed out the perceived competition between WL and local community organisations:

"...some organisations in some of the areas were concerned that they'd be in direct competition to us for funding." – SBL

Respondents reflected on not only the challenges, but how to overcome these. Overall, they identified six key strategies for tackling the problems of engagement.

First, making the community meetings and events as accessible as possible for all groups and individuals in the area was thought to be a very effective way of encouraging local participation. Flexible meeting times, scheduled daytime meetings, familiar venues, and language translators were the most typical suggestions made by the respondents.

Second, sound knowledge about the area and its people prior to the community consultations was thought to be important for understanding the local politics. The third solution was being upfront and truthful with the communities from the start about the resources available.

The next strategy offered was communicating realistic expectations and effective use of resources.

"...you just have to be really honest about it from the onset...I think you need to be frank from the beginning about how that it going to work." – NDG

Another strategy was the use of community organisations that could be trusted and who represented the local diversity and had an entry to the communities.

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Some respondents noted a buy-in from the community leaders and champions to gain trust. Some suggested a research of the potential co-host organisations in the area, and be clear about roles, responsibilities and remunerations before the engagement process.

Finally, organisations responsible for the engagement should be flexible about how they work with the communities. The systems and procedures used by the programme should be adaptable to specific community needs.

9.8. Impact of Well London CEP

This section examines the perceived impact of the WL CEP on the local communities, WL partners, and the design and delivery of the projects.

9.8.1. Impact of CEP on Communities

The communities were at the heart of the WL CEP and it was expected that the communities would be the main beneficiaries of the engagement process. The respondents interviewed identified both positive and negative impacts of the CEP, and these are summarised in figure 9.9.

Figure 9.9 – Impact of CEP on communities

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Impacts of CEP on Communities

➢ **Positive impacts**

    ○ Better awareness of people in the community

    ○ Increased awareness of local services

    ○ Opportunity to socialise and increase social network

    ○ Increased sense of belonging and community spirit

➢ **Negative impact:**

    ○ Fragmentation of the communities

    ○ Inequity of access to projects

    ○ Loss of enthusiasm due to delay in delivering projects

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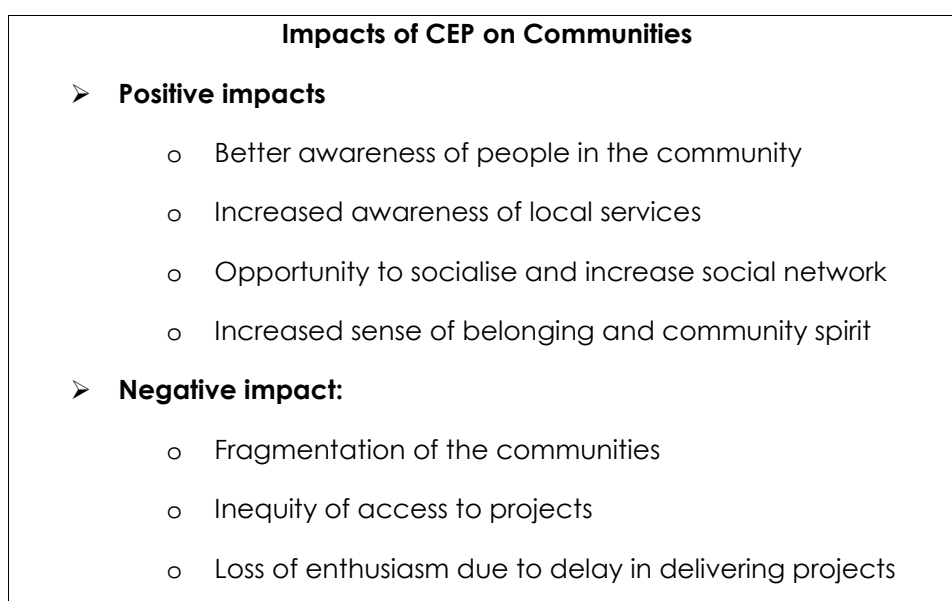
The first positive impact on the communities was a better awareness of the people in the local areas. The CEP also provided an opportunity for the

community residents to find out about the local services available to them and how they could access these services.

> *"… [the CEP]…brought about some indirect health benefits in increasing people's awareness of other local people or organisations or services at a local level." – KTA*

Second, the partners felt that the CEP gave the residents an opportunity to socialise which made them happy and improved their general wellbeing. This socialising helped people to create and expand social networks within the community. The residents had an opportunity to talk about their concerns with other people experiencing the same or similar issues. This sharing helped the local residents to create a social safety net where people were not isolated and lonely in dealing with their concerns.

Another community benefit was a creation of sense of belonging and community spirit which emerged from understanding a shared responsibility for needs and possible solutions.

> *"…community spirit…people having a chance to hear about living locally from a different perspective that perhaps they had never heard before." – KTA*

In terms of the negative impacts of the CEP, some partners expressed a view that the CEP had fragmented the communities as residents had unequal access to the consultation process and the projects. The respondents pointed out that there were community groups who stood to benefit from the WL CEP more and those who felt excluded.

> *"You get the sense that actually Well London has had quite sort of a fragmentary impact as well…" – NDG*

Further, as a result of the delay between the community engagement events and the actual delivery of the projects, a number of the respondents said that in this period, the communities lost their enthusiasm and belief in community-driven interventions; and they eventually disengaged from the programme.

> *"…quite a number of people who were very enthusiastic about getting involved with Well London…then…these inevitable delays before things were up and running" – APL*

9.8.2. Impact of CEP on Well London Alliance Partner Organisations

The list of the CEP impacts on the WL partner organisations is shown in figure 9.10. There were also positive and negative impacts reported.

Figure 9.10 – Impact of CEP on WL Partners

Positive impacts:

➢ Organisational learning, particularly about methods of community engagement

➢ Increased knowledge of the needs of the communities

➢ Expansion and adaptation of interventions

➢ Spin-off effect – access to other sources of funding

➢ Academic peer-reviewed outputs

➢ Source of information and evidence

➢ Reinforced community development approach

➢ Expanded capacity and infrastructure

Negative impacts:

➢ Significant organisational burden

➢ High levels of stress

The first positive impact identified by the WL partners was organisational learning. A number of respondents said that the lessons learnt from this process would be mainstreamed and adapted in other community events. Some partners said that they had already modified their community approaches in other projects, particularly the methods of community engagement used.

"Well London…informed quite a lot of the projects that I was delivering elsewhere in terms of the engagement methods." – NDG

Some partners noted that they had learnt more about the needs of the communities they served and expanded specific types of interventions they provided. Another important impact highlighted by a number of respondents was the spin-off effect for their organisations. Their experiences with WL allowed them to get access to other projects and similar sources of funding:

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"I guess that the fact that we were engaged with the Well London programme was what sold Redbridge work. So, it has influenced the organisation by actually bringing additional funds in to underpin that area of activity." – ARU

The University partner was able to produce peer-reviewed publications which were important for their organisational development. Although other organisations were less interested in academic outputs, they welcomed peer-review articles as a source of information and evidence which helped them to better understand deprived communities and influence decision-making. The CEP helped the alliance partners to inform and influence decision-making at various levels of government through their communication of the findings of the CEP.

"The possibility of producing peer-reviewed outputs and making it contribute to knowledge and understanding of the determinants of health at the local level." – ARU

In some organisations, the WL CEP helped to reinforce the community development approach as a key organisational strategy. It also gave these organisations an evidence-base for the community engagement work they intended to do.

"…it has…probably strengthened Central YMCA's resolve in terms of community engagement as a process…the Well London methodology and approach reinforced that as our preferred methodology…we tend to have done things in a particular way without necessarily always knowing quite why. Well London helped from the process of saying, "Ha! That's what we do" to "Ha! that's why we do it". So I think it has helpful organisationally." – MHY

A number of organisations expanded their capacities and infrastructure. Some organisations established new roles and management processes; while some created new units within the organisations. Importantly, the new members of teams did not only contribute to the expansion of human resource capacities, they brought along a dynamic mix of skills, experiences and knowledge around community engagement and health promotion.

For many organisations however, the WL CEP created a lot of work and placed a huge burden on their managerial and administrative systems. Time and

resource constraints led to high levels of stress within organisations and were perceived to be a negative impact of the engagement process.

"…we hadn't planned on having to be the lead partners in the boroughs." – TCS

It was clear from the interview accounts that the perceived impact was to a large extent determined by the size of the organisation involved. For example, there was a partner organisation that felt that the WL CEP had little or no impact on their organisation because compared to the overall size and resource-base of this organisation, WL was a small project and therefore its positive or negative impact was negligible.

"…in terms of Well London, that for the xxx is a very small project in lots of ways. The xxx is a really well-resourced and heavily-funded organisation which…has got plenty of its own money and will run initiatives and programmes that are far, far bigger than Well London." – KTA

9.8.3. Impact of CEP on the Design and Delivery of Projects

Overall, the partners interviewed felt that the CEP had a limited impact on the content of the health promotion projects they delivered under the WL. The key reason was that the bid had been written in such a way that there was very little room for change in the design, scale or scope of the interventions proposed.

"…in terms of designing and delivery coming from the community itself, I don't think we're there yet. I think what happened is that we engaged with them but we already had some of the projects in mind." – ARL

"…the projects were to some extent predetermined of necessity by the requirement of the lottery, to submit a bid which had concrete projects in it." – ARU

"… [the CEP] couldn't necessarily feed directly into the design of the project that was already very defined…I don't think there was always direct correlation." – CDG

Some partners felt it was difficult to use the information collected through the CEP. Although the community engagement was entertaining and fun, its contribution to how to deliver specific projects was limited. Many partners said that they had to go back to the communities and local stakeholders to collect

additional information to help them to plan the projects. The respondents also noted that many needs identified by the communities were beyond the scope of WL and therefore could not be addressed within its timeframe and resources. For example, some communities requested new play areas which would require substantial capital funding which WL did not have.

> "…I'm not saying that community engagement is not important because I think there are lots of reasons why we do it. And I think if we looked back and analysed the things that people told us, that were of concern to them, quite often they weren't about things that we could actually deliver upon." – KTA

The CEP did not manage to increase awareness of and participation in WL projects as expected by the CEP organisers. Many residents had never heard of Well London prior to starting the projects:

> "…out of the ten [residents] today, only three of them know about Well London… I mean I had no feedback from the community engagement process saying these are the names of women who are interested in 'Can Money Buy Happiness.'"" – SCS

The respondents reflected on only marginal changes they could introduce within the projects as a result of CEP. The modifications that were introduced included changes to the combination of projects within each area; some changes to the process of delivery; changes to who engaged in the projects delivered locally; identification of possible local delivery partners; and some projects specific to identified community needs.

Some partners used information from the CEP to decide which projects they delivered in the areas. For example, food growing was an idea that came up during the CEP and Groundwork was able to redesign its food projects to deliver food-growing sessions.

> "…food growing was something that came up as an idea through the community cafe, and that is certainly something that we've been able to deliver, working in partnership with local schools and other local partners." – NDG

Some thought that the CEP helped them better understand the local communities and design more creative and interesting interventions in response.

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> *"…it identified what the key concerns and issues were for the local communities, and did some creative thinking about the ways in which projects could be delivered." – ARU*

Some noted that the CEP helped them realise that it was impossible to deliver the projects in the way that had been envisaged earlier. A number of respondents said that they had thought and rethought the process of intervention delivery. However, they did not always attribute these modifications to the CEP. They argued that the changes they introduced resulted from the logistical rethinking and the processes of development within their own organisations. They believed that the CEP could have been useful in this process but it was not:

> *"Everybody's programmes have changed from how we first articulated them to how they are delivered now…I know we've changed our minds millions of times but we've done it on our own. We haven't done it in consultation with other partners or with communities." – KTA*

Some partners were able to identify through CEP the local agencies that helped them deliver projects in the communities. This impacted the way the projects were then commissioned and delivered.

> *"Firstly, it [CEP] identified key local community organisations and individuals within the community that it was possible to work in partnership with to develop the programme downstream. It established the process of getting to know the local voluntary and statutory sector stakeholders, as well as the local communities. – ARU*

> *"…we went to…the cafes and we found a…delivery partner…potentially they could deliver Cook and Eat course." – ARL*

The CEP also emphasised the needs of the individual communities and illuminated specific activities that were of interest to the residents such as martial arts for children, chair-dancing for seniors, and time-banking which had not earlier been part of the project options.

Chapter 10 – Results:

==Community Engagement Process and its Impact – Evidence from Documentary Sources==

10.1. Introduction

This chapter presents results of the analyses of the documents related to the Well London CEP and the target boroughs.

The key focus of the ==evidence from documents== was on the impact of CEP on the design and delivery of programme interventions. This was examined through a) what the documents (as reflected in quarterly reports to the Big Lottery Fund) said about the perceived opportunities and challenges and how they shaped the WL programme, and b) the analysis of the actual changes in the content and combination of the interventions delivered. The information was analysed to reflect the dynamics of the process, to capture which opportunities and challenges were observed in the beginning of the process and whether and how these were maximised or minimised throughout the programme. The analysis of the project changes examined which interventions had been planned in the original project bid and contractual documentation, and how the communities expressed their local priorities (as reflected in the café notes, Local Area Agreements (LAAs) and CAW documentation) and to what extent these local priorities were integrated in the programme plans and project implementation (as reflected in the PIDs and quarterly reports). The impact was examined across eight of the participating boroughs. .

The quarterly monitoring reports (QMR) covered the period from October 2007 to March 2009.

10.2. Opportunities of CEP

A number of benefits of the CEP were identified in the documents reviewed. These benefits are presented in figure 10.1 below.

The CEP impacted on the delivery of new projects, particularly in the areas where 'nothing' had happened before. The partners reported that the CEP was useful in giving them a first-hand look at the communities and interact with them so that they could better understand the way the projects could be delivered successfully. The CEP helped to note the available physical resources in the communities and how they could be effectively utilised (QMR1).

Figure 10.1 – Opportunities of CEP

Opportunities of CEP

➢ Community empowerment

➢ Building capacities of the WL and local organisations

➢ Gaining information about local areas and design of interventions tailored to the areas' specific needs

➢ Possibilities for additional funding

➢ Research and evaluation opportunities

➢ Marketing, networking and promotional opportunities

➢ Opportunities to document lessons learnt

Towards the end of the programme, communities were getting together to address issues in their neighbourhoods, they were getting their voices heard and local authorities were taking notice; they were also celebrating their communities and achievements and taking pride in their communities. Several projects recorded laudable successes in both the number of participants and the impact of the projects on the residents and the community. The DIY Happiness project had engaged 320 women across the 20 communities; 93 people had been trained to undertake the MWIA in 19 communities; over 300 residents from 10 communities had participated in the cook and eat sessions; over 8000 residents had attended the community feasts held in the 20 WL communities;

The CEP presented an opportunity for the alliance organisations to increase their staff number and skill-set in response to the demands of the process. Eight new members of staff were recruited in the first quarter across LHC, the Arts Council; UEL, YMCA, SLAM, and LSX (QMR1). In the second quarter, an additional six members of staff were recruited for YMCA and SLAM (QMR2).

There was also significant organisational capacity building through training opportunities, communication, facilitation, and personal and team development.

The CEP provided a platform for obtaining additional funding. In the first quarter, UEL submitted a grant proposal to the Wellcome Trust to support its evaluation survey and the funding was secured by the second quarter (QMR1; QMR2). The Greenwich Council offered to contribute towards the post of a community development worker in the borough (QMR4). Some partners obtained funding from local Primary Care Trusts (PCT) to cover additional staff costs incurred from borough coordination; SLAM was commissioned by the Arts Council to provide MWIA training for arts organisations in London, and the London Borough of Lewisham integrated MWIA into its evaluation framework for the borough's Cultural Strategy. A funding strategy was also developed towards the end of year-one which progressively looked into ways of obtaining continued funding beyond the BLF funding

The CEP provided an opportunity for participatory action research and evaluation. Researchers at UEL were able to develop an innovative framework to evaluate complex interventions and put together data for academic publications.

The CEP presented a wide range of marketing, networking and promotional opportunities including electronic and print media; online profile website; wiki links; electronic bulletin; community fun days, community fairs and other community events in the target areas. CEP helped to engage with formal and informal local networks, including tenant and residents' associations, public health units, public health professional sector, conferences, and government sector (QMR2; QMR6).

One of the innovations introduced by WL at the very early stages of the programme was a risk register which documented various programme challenges and their effects. This risk register was routinely revised and updated throughout the programme and is a good source of information on what could go wrong during a CEP and how to mitigate the risks (QMR1-2; QMR4-6).

10.3. Challenges of CEP and their Impact

Several challenges to the CEP were documented throughout the course of the programme. Ten different challenges experienced by CEP were documented in the sources reviewed and are presented in figure 10.2 below.

Figure 10.2 – Challenges of CEP

Challenges of CEP

➢ Difficulties with the recruitment of CEP participants

➢ Difficulties with buy-in and local support

➢ Time constraints and delays

➢ Difficulties with borough coordination

➢ Interdependency of projects which resulted in further delays

➢ Tensions with co-host organisations

➢ Difficulties of working in areas with concurrent regeneration projects

➢ High turnover of staff within the WL partner organisations

➢ Changes in the political and financial environment

➢ Lack of visual identity for the programme

Problems with the recruitment of participants in the target communities were evident in the first stages of the programme (QMR1). There were reports of participation of residents from outside the LSOA and non-participation of a significant number of residents who were the focus of the health promotion interventions (QMR1). The engagement of participants varied across the areas, but was particularly noticeable in Brent and Croydon in the phase one; and Southwark in phase two. This raised concerns about who determined the area priorities and the interventions to be delivered. An important impact of this problem was the fact that the CEP had to be extended to include street interviews which proved to be an effective way to collect data from local residents; and the street interviews were subsequently used as an integral part of the engagement process in phase-two, both for collecting data and for raising awareness about upcoming CEP events in the areas (QMR1).

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The documents reported that the process of engagement was difficult at both individual and organisational levels. The inability to effectively engage the community and local organisations became even more apparent at a stage in the programme when the partners found it difficult to get local delivery partners and volunteers for some of the projects. Thus, by the middle of the second year, the WL Delivery Team (WLDT) had become operational in five areas, and the contracts were signed in another 10 areas, but WL organisations were still experiencing difficulties recruiting volunteers. These challenges necessitated the amendments of the project milestones and timeframes; while in some areas the partners had to abandon the projects they could not deliver. For example, in Brent, Ealing, Hammersmith and Fulham, and Hounslow, SLAM decided not to deliver the Changing Minds project because they were unable to find any local organisation interested in delivering it (QMR6).

A number of documents reported on the delays in the CEP and WL projects in the first year (QMR4-6). The delays were due to the fact that the CEP took longer than anticipated and resulted in tensions with co-hosts and local partner organisations. In some areas such as Greenwich, the delays resulting from the loss of its co-host continued throughout the entire programme (QMR3-4; QMR6).

Some time was lost due to the commissioning bottlenecks and inability to recruit suitable local delivery partners (QMR1). At least three WL organisations reported such problems. LSX and YMCA found it difficult to identify local organisations to manage the WLDT in several boroughs; and SLAM reported difficulties in finding organisations to conduct the MWIA in some boroughs such as in Enfield.

The management and coordination of WL activities at the borough level proved to be a challenge. The WL partners had to select co-hosts, administer funding, build up local advisory groups and develop their terms of reference. It was a continuous challenge as report after report noted the significant amount of resources and commitment required to fulfil this role. This administrative burden affected prompt and timely delivery of their organisations' projects and subsequent visibility of the programme at the local level.

Delays in the CEP and project set-up meant that other projects had to be delayed. For example, the MWIA which was designed to measure the impact of other projects on communities could not be delivered on time because

there were no projects to assess by the time of its original schedule (QMR5 and QMR6). In addition, some documents noted that the original expectation was that the critical mass of the interventions delivered at the same time would produce a synergistic effect which would be greater than the sum of the effects by each individual project. However, due to delays of some activities, achieving such an effect proved to be difficult.

There were several documented problems with recruiting appropriate co-hosts, maintaining good working relationships with them, and developing alternative provisions when the co-host pulled out. The co-host in Greenwich lost their government funding and had to close down in the first year of the programme and WL was unable to find a suitable replacement (QMR1-2). This typically started a series of delays which led to very late delivery of projects in Greenwich. Many local organisations were thought to be unsuitable because they were either too small or not interested in taking up a significant workload for relatively small remuneration. Eventually, it was decided that a community development worker would be recruited and the cost shared between the WL and the local authority (QMR4-6).

Many organisational challenges experienced by the CEP had an impact on the processes of engagement and the need to revisit some agreements and procedures. For instance, some documents show that in order to gain local support and retain volunteers, WL had to reconsider its stand on incentivising for participation (Q1). The programme built partnerships with local service providers such as leisure centres to identify acceptable ways of incentivising volunteers. The Arts Council re-evaluated its organisational commissioning process and streamlined it to become less cumbersome and more efficient.

On-going area regenerations notably in Ealing and Hackney, and other consultations notably in Southwark, affected the CEP. In Southwark, the CEP had to be postponed due to other planned community consultations and a wish to avoid consultation. The regeneration project in Ealing was a massive logistical problem as a large part of the area was designated as an industrial land and almost the whole community had to be moved out from the LSOA (Q2). The residents were anxious and uncertain about their future and it was difficult to encourage them to think about such issues as diet or physical activity.

The programme experienced prolonged periods of staff vacancies and high staff turnover. This has an effect on the continuity of projects activities and the relationships with the communities (Q1-Q2 and Q4).

During the second quarter of the programme, the City of London elected a new (Conservative) Mayor. The programme had been commissioned under the Labour governance and it was imperative to gain the support of the new administration (Q2). In addition, some partners (e.g. Central YMCA) lost part of their core funding, which again affect some of the activities provided (Q4).

The lack of visual identity for WL proved to be an issue. Well into the second year, WL did not have a recognisable visual identity or attribute (Q2, Q4). The logo competition took longer than expected and there was no distinguishing branding for promotional materials (Q1, Q2 and Q4).

10.4. Impact of CEP on the Content and Combination of the Projects Delivered in the Areas

The BLF WL project bid was designed around five main portfolio themes: food poverty, physical activity, mental wellbeing, open spaces, and culture and tradition. There were 14 projects proposed in the bid (Figure 10.3) which aimed at increasing opportunities for making healthy eating choices; increasing opportunities for healthy physical activity; improving mental health and wellbeing and perceptions of mental wellbeing in the community; and increasing community capacity and cohesion (WL Strategy, 2007).

Figure 10.3 – Well London projects designed at the project-bid stage

Mental Health and Wellbeing	➢ Changing Minds ➢ Mental Wellbeing Impact Assessment (MWIA) ➢ DIY Happiness
Healthy Food Access	➢ Buy Well ➢ Eat Well
Healthy Physical Activity	➢ Activate London
Healthy Open Space	➢ Healthy Spaces
Arts and Culture Projects	➢ Be Creative Be Well
Projects for Young People	➢ Youth.com Unity
Community Engagement	➢ CADBE ➢ Well London Delivery Team (WLDT)
Others	➢ Active Living Map ➢ Wellnet ➢ Training Communities

These projects were conceived in broad terms of what they could achieve in their generality and in all target communities. However, the CEP was supposed to inform the final design and delivery according to what the needs identified were. The process of shaping the project portfolios towards the needs of the specific communities was to be achieved through a) WL community consultations; b) review of the local situations, community profiles and LAAs; c) consultations with local stakeholders and residents during CAWs; and d) finalising and agreement of the portfolios at the PID (Well London Strategy, 2007).

10.4.1. Projects Delivered in Well London Areas

The themes and projects delivered in all WL areas are presented in table 10.1 below. All the projects were in the fields of healthy eating, healthy physical activity, mental health and wellbeing, arts and culture, and open spaces. However, they differed in their names, specific activities, target audiences and duration (PIDs).

Some activities were one-off events, for example, community feasts; while others were scheduled to last for weeks, such as the audio-visual skills training, DIY Happiness, and community gardening. Some projects cut across two or

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more themes, for example, community gardens and allotments helped enhance community cohesion, provide healthy physical activity and self-grown healthy fruits and vegetables, and improve mental wellbeing.

A few activities (e.g. community feasts, carnivals and volunteer teams) were delivered across all WL areas. Some were delivered in one LSOA but involved people from all target areas. For example the WL World Cup held in 2010 in Hammersmith and Fulham, involved young people from all 20 communities (Well London website). But many projects were area-specific. For example, the Pocket Park redevelopment project in Brent was identified as a priority by the residents who felt that the park, which was situated on a street right in the middle of the LSOA, had good potential to be a healthy open space but had to be cleaned up. The residents got together to clean up the park, plant trees, repair benches, mend the fences and make the park safe for use (Well London website). Some projects developed from the success of other WL activities. For example, the park redevelopment project described above went so well that the residents decided to have a community feast in the park to celebrate their achievements and to take ownership of the park in their community (Well London website).

Buy Well was delivered in 10 boroughs; these boroughs were identified during the CEP as the areas having particular problems with accessing healthy foods; but the actual delivery of the projects varied across the boroughs depending on how the residents wanted the projects delivered.

The Activate London project aimed to increase physical activity, and the CEP helped to determine what specific activities the local residents wanted to have and who the target populations (young people, older residents, and women) were. As a result, some communities had dancing for older residents, some had soccer training for young people, and some had women-only sessions, and some had mini-Olympics which involved all age groups.

The mental health and wellbeing projects included the DIY Happiness, WMIA and Changing Minds projects. The DIY Happiness ran 8-week workshops, exploring what made women happy and using humour and creativity to increase residents' resilience and help them relax, cope with and reduce life's stresses, increase their energy and optimism and eat happily. These activities

also included flower arrangements and laughter yoga classes. The project also funded 60 "Dare to Dream" projects, giving female participants £500 each to explore activities which made them happy and which would help other women in their neighbourhoods. One woman, for example, started a "free massage and a listening ear" offer for unemployed mothers like herself in a free space she had negotiated in a community centre on the estate (Well London website).

The MWIA conducted 31 workshops in nine boroughs; and by the end of the third year, MWIA had provided action learning for 93 individuals across 19 WL boroughs. The projects it assessed and reported varied: Healthy Walks in Ealing; Activate Yoga in Westminster; Big Chair Dance in Haringey; Buy Well in Lewisham; Healthy Spaces in Brent, Greenwich, Hounslow, and Kensington and Chelsea; and Cook Grow Eat in Barking and Dagenham (PIDs; Well London website).

The Changing Minds project recruited and trained local people who had direct experience of mental ill-health, and these people then delivered mental health awareness to their neighbourhood (PIDs; Well London website).

A number of projects were aimed at increasing community capacity and cohesion. For example the WLDT and community ambassadors helped to bring the community together and mobilise residents around WL activities, as well as signposting them to local services and resources available in the community. The Training Communities project provided free personal support package and group training for residents and communities for personal or community development.

Other projects like the Active Living Map, Well-net, and the Youth.com used electronic technology to provide information about healthy living and wellbeing services and resources in the community such as locations of parks, leisure centres, healthy food stores and food coops, health advice and information; and to get people together through social networking and attending events. These projects were accessible to all areas. The Youth.com project addressed the issue of disengaged youths in the community. The project supported and incentivised young people aged 16-24 years old to make healthy decisions and achieve healthy lifestyles through project ideas

they have come up with themselves. The initial 20 young ambassadors that were recruited and trained have been able to reach out to over 2500 young people in their communities.

There were also a number of celebratory events to acknowledge the efforts and successes of the communities during the programme. Community feasts and carnivals were held in all 20 neighbourhoods of the WL programme. The London Health Commission also held an awards ceremony in June 2010 and recognised the Lansbury Gardening Club; the Junction Residents Association of Brent for improving the Pocket Park; and a WLDT volunteer in Greenwich for her outstanding contributions which included the development and maintenance of the WLDT local website in Greenwich (Well London website, PIDs).

Table 10.1 – WL themes, projects and impact of CEP		
Themes	**Projects delivered**	**Impact of CEP to Well London Projects**
Healthy Eating	*Community Feasts (all 20 boroughs)* *The 'Gherkin' Newsletter* *Eat Well* o *Memory Soup Project (Canonbury)* o *Cook and Eat sessions* o *ActivEAT* *Buy Well* o *Mobile Food Stores (e.g. Barking and Dagenham)* o *Food Coops (Ealing, Hackney, Hammersmith and Fulham, Lambeth, Lewisham, Newham, Westminster)* o *Healthier Options Award (Newham)* o *Café Relax (Tower Hamlet)* o *Buy Well Retail Projects* o *Pop-up Shops*	The CEP revealed that the issues around healthy eating in the communities revolved around: 1) Lack of cooking skills 2) Lack of access to healthy foods 3) Inability to afford healthy foods 4) Lack of opportunities to come together as a community to share and eat together The Well London projects therefore aimed to address these issues by providing cook and eat sessions to enhance cooking skills and healthy food choices; mobile food stores, food retail projects and food co-ops to provide access to affordable healthy options; and community feasts, cafes, memory soup projects to provide opportunities for coming together to eat and share stories and experiences as a community. The newsletter provided information about these projects and raised awareness of healthy food options
Healthy Physical Activity	*WL World Cup* *Activate London* o *Boxing classes* o *Activate Yoga* o *Women-only classes and sessions* o *Information on leisure centre concessions available to certain individuals and groups* o *Chair dances*	The CEP revealed that the issues around physical activity in the communities revolved around: 1) Lack of access to affordable physical activities 2) Lack of women-only services in gyms and leisure centres 3) Lack of appropriate activities for young people, elderly residents and disabled persons 4) Lack of opportunities and free spaces and facilities for recreation and physical activity

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Table 10.1 – WL themes, projects and impact of CEP		
Themes	**Projects delivered**	**Impact of CEP to Well London Projects**
		5) Lack of exciting activities which could entertain, motivate and bring people in the communities together through physical activity The Well London projects addressed these issues by providing community sporting and physical activity events and competitions to bring the community together around physical activity; providing concessions and information about concessions available to certain groups and individuals in the communities to aid access to facilities; organising women-only exercise and swimming sessions to remove cultural, religious and gender barriers to physical activity; providing specific exercise classes that the communities had indicated that they were interested in such as boxing, football, dancing and healthy walks groups; providing age-appropriate activities for the young residents such as disco and hip-hop classes, Salsa in the Street events and Latin Rhumba classes.
Mental Health and Wellbeing	*DIY Happiness* *MWIA (Ealing, Westminster, Lewisham, Brent, Greenwich, Hounslow, Kensington and Chelsea, Barking and Dagenham)* *Changing Minds* o *Changing Spaces* *Dare to Dream*	The CEP identified mental health and wellbeing issues such as: 1) Isolation 2) Fear of crime and lack of safety 3) Lack of opportunities and outlets to express creativity 4) Perceptions and misconceptions about mental health The Well London projects addressed these identified issues by using the MWIA project to assess the effects of the other projects on the mental health and wellbeing of the residents; providing opportunities and funding for residents to express creative ideas and to learn new skills such as

Table 10.1 – WL themes, projects and impact of CEP		
Themes	**Projects delivered**	**Impact of CEP to Well London Projects**
		flower arrangement and audio-visual techniques; providing opportunities for socialising to reduce the impact of isolation; and using the Changing Minds to address the perceptions and misconceptions about mental health in the community.
Arts, Culture and Tradition	*'It's a London Thing' Carnival* *Love Croydon Carnival* *Queen Crescent Community Festival* *Acton Carnival* *Be Creative Be Well:* o *Intergenerational Storytelling; Stories in the Street (Lewisham); Newham Music Night Project; Latin American and African Dances (Newham); Photography workshop (Newham); Craft Fair (Newham); My Life: Bellingham (Lewisham); Drumming classes; Harlesden Youth Theatre (Brent); Entelechy Arts and Capital Age Festival (Haringey); Snapshot Canonbury Photography and Digital Arts (Islington); Song and Music Project (Greenwich; Summer Play Scheme (Lambeth)Trust Arts Project; Stitches in Time (Tower Hamlets); City Gateway Video Diaries; Arts in Education Network (Waltham Forest); Avenue Youth Project (Westminster); Me and Us (Barking and Dagenham); Creative Kilburn*	The issues identified in the CEP around arts, culture and tradition were: 1) Lack of intergenerational and intercultural interactions in the communities 2) Need for celebratory events 3) Lack of opportunities and outlets to express creativity 4) Lack of opportunities to acquire art and creative skills The Well London projects addressed these issues by providing intergenerational and multicultural celebratory events and festivals in the communities; opportunities to learn about other cultures and generations through cultural events and storytelling; opportunities for expressing creativity and learning new creative skills through arts, music and technology classes.

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Table 10.1 – WL themes, projects and impact of CEP		
Themes	**Projects delivered**	**Impact of CEP to Well London Projects**
	(Camden); PINS Redevelopment of Handscroft Road Centre (Croydon); A Community Film Project (Enfield); HISTORYtalk (Kensington and Chelsea); Somali Women's Multicultural Celebration (Hammersmith and Fulham); Circus Skills Workshop (Hammersmith and Fulham); The Big Chair Dance	
Healthy Open Spaces	*Healthy Spaces Club (Woodberry Down, Hackney)* *Handcroft Community Centre Redevelopment Project (Croydon)* *Pocket Park Redevelopment and Community Feast (Brent)* *St. Quentin's Kitchen Garden and Allotment (Kensington and Chelsea)* *Lansbury Gardening Club (Tower Hamlet)* *Urban Bee-keeping* *Window boxes and flowerboxes*	The issues identified in the CEP around healthy open spaces were: 1) Lack of green spaces in the communities 2) Inappropriate use of open spaces 3) Lack of safety in open spaces 4) Dirty and unkempt green spaces 5) Lack of opportunities to create and maintain green spaces The Well London projects addressed these identified issues by encouraging the best use of available spaces and the use of window and flower boxes to beautify the environment and homes; organising the cleaning up and maintenance of disused open spaces; creating a sense of ownership of the spaces available; facilitating the provision of allotments and gardening spaces and clubs for interested residents; providing opportunities for green activities such as bee-keeping and growing own food.

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10.4.2. Re-shaping of Project Portfolio – Case-Studies of 8 Boroughs

This section looks at eight boroughs in greater details and reviews how the original proposal of 14 projects was re-shaped based on the needs and priorities identified in these areas in the consultation process. An outline of what was identified as LAA priorities; what was expressed during the CEP; and what was eventually planned and delivered in the eight boroughs, is shown in tables 10.2 to 10.9 below.

10.4.2.1. Community Priorities Identified Through Community Consultations and LAAs

There were 10 key themes identified as priorities at the community cafés in the eight boroughs. However, the two main priorities in all the areas were: community building and cohesion, and young people. In terms of young people, Barking and Dagenham, Camden, Ealing and Westminster pointed to anti-social behaviours and gang cultures; Waltham Forest and Hackney described their youths as disaffected; Greenwich pointed to a fear of young people. They all said that provision of activities, training and skills for the young people was a priority for their areas.

Other groups identified as priorities included older residents (Ealing, Southwark, Waltham Forest), children (Southwark, Waltham Forest), and women (Greenwich, Waltham Forest). One area (Hackney) wanted intergenerational activities to bring different groups in the community together.

Poor built environment and the lack of green spaces were identified in four areas (Ealing, Greenwich, Hackney and Waltham Forest); and Barking and Dagenham identified lack of, or poor community facilities.

There were three issues identified as priorities with healthy foods: lack of food literacy (Hackney, Westminster); lack of access to healthy foods (Ealing, Westminster); and affordability (Southwark).

The lack of information about opportunities and services available was also identified as a priority in two areas (Hackney, Waltham Forest).

The LAAs also identified several priorities across the different boroughs. However, the most common priorities were: children and young people; stronger and safer communities; tackling inequalities; skills and employment; and cleaner, greener sustainable environments.

Although many priorities identified by the CEP and the LAA were common, they were often expressed differently; for example Camden expressed its priorities in terms of the vision of what they hoped Camden would look like; Southwark outlined what needed to be done; and Hackney focused on what had to be done with its different groups of residents to achieve their priorities. Overall they included eight main cross-cutting issues that were found across all eight boroughs (Figure 10.4).

The main difference noted between LAA and CEP-identified priorities was the access to affordable good quality housing. This priority was identified in the eight LAAs examined but not in the CEP documents, although some residents at the cafés mentioned housing as a key priority for them. The issue was not taken forward largely because this priority was outside the scope and resources of the WL programme. However, to at least partially address the problem, Groundwork delivered some home improvement projects such as window boxes and flowerboxes which helped to improve the aesthetics of some areas.

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Main Themes and Issues

- **Community engagement and cohesion**
    - o Strong united and cohesive communities
    - o Civic participation
- **Safety in community**
    - o Reduce crime and violence, including domestic violence
    - o Reduce anti-social behaviour
    - o Tackle gang culture
- **Focus on vulnerable groups**
    - o Children and young adults
    - o Older residents
    - o Residents with long-term conditions
    - o Disadvantaged groups
    - o Unemployed and workless adults
- **The environment and local open spaces**
    - o Sustainability
    - o Energy efficiency
    - o Recycling
    - o Green spaces
    - o Built environment that promotes healthy lifestyles
    - o Pride in one's environment
- **Increase skills and capacity of residents**
    - o Training
    - o Education
    - o Employment
- **Economic viability of the area**
    - o Enterprise
    - o Local businesses
    - o Retaining and building wealth in the community
- **Housing**
    - o Access to good, affordable housing
    - o Affordable home ownership
- **Healthy lives and lifestyles of residents**
    - o Promote healthy lifestyles
    - o Healthy weights
    - o Physical activity
    - o Mental wellbeing
    - o Healthy food access

10.4.2.2. Community Needs and Well London Portfolios

Overall, the areas reviewed addressed the priorities expressed during the CEP. Thus, about ten projects were agreed and delivered in each of the eight boroughs reviewed.

In Barking and Dagenham, the LAA and CEP priorities were similar regarding youths, better community, access to information and skills, and reducing health inequalities. The WL projects which addressed these included Youth.com, community feasts, and capacity building (signposting, MWIA, WLDT) (Table 10.2).

The major focus of Camden's LAA priorities which was shared by the CEP priorities was around building a community that was inclusive and vibrant; the WL projects which addressed these included festivals and community feasts (Table 10.3).

In Ealing, safety; community cohesion; efficient and affordable local services, especially for physical activity; and better environment and community spaces, were the similar priorities identified in both the LAA and CEP. WL provided signposting to local services and increased uptake of physical activity through the Activate London project; and Healthy Spaces project which also encouraged the use of the local community hall (Table 10.4). In Ealing, mental wellbeing activities were focused specifically on reducing the negative experiences of the regeneration project going on in the area. This was an example of a situation where the projects were tailored to the particular needs of the area.

In Greenwich, both the LAA and CEP identified similar priorities around engaging young people, building a cohesive community, and taking pride in the physical environment. The WL projects to address these priorities included Youth.com, creative workshops for young people, DIY Happiness, community feasts and community gardens (Table 10.5).

In Hackney, there was only one similarity between the LAA and CEP priorities: workless and disaffected youths. The WL programme provided support to the local youths through Youth.com and capacity building (Table 10.6).

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There were two main similarities between the LAA and CEP priorities in Southwark: a safer community; and provision of activities, education, training and employment for youths. Well London improved access to green spaces in the community, and delivered Activate London for youths (Table 10.7).

Waltham Forests' LAA and CEP priorities were similar to those of Southwark: community cohesion and inclusiveness; and skills and employment for youths. The WL projects delivered included community feast, Youth.com, WLDT, and signposting (Table 10.8).

In Westminster, similar priorities identified in the LAA and CEP were: strong and cohesive community; employment, training and skills for young people; and vulnerable groups, children, women and the elderly. The WL delivered community feasts, Dare to Dream, DIY Happiness, Youth.com, and increased volunteering opportunities through the WLDT (Table 10.9).

The issues of dog-fouling and dangerous dogs, and the detrimental effects on the local environment and the mental wellbeing of residents were brought up at several community events. However, no direct intervention was provided through the portfolio of projects delivered in any of the areas. Cleaning up and beautifying parks and green spaces were implemented as part of the Healthy Spaces project contained in the original bid, but was not as a direct response to the issues around dogs; for example in Hackney.

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Table 10.2 – Barking and Dagenham

LAA Priorities	Community Café Priorities	Projects Implemented
Skills and employment (improve skills to raise household incomes) A better place to do business (attract and retain businesses; encourage business start-ups) Housing (access to good and affordable homes) Health Inequalities (reduce mortality, smoking and obesity rates; improve mental wellbeing) Children and young people's life chances (increase qualification achieved; support for children with learning difficulties; reduce teen pregnancy; more activities for children and young people) Being safe and feeling safe (safer neighbourhoods; reduce crime and re-offending; reduce anti-social behaviour; reduce domestic violence) A strong community (listen to people to help them better influence decisions; ensure fair access and opportunities for people to get on well together)	Youth and anti-social behaviours; crime and safety issues	Youth.com
	Need for community building and community spirit	Community Feast Be Creative Be Well – Me and Us project
	Lack of access to affordable healthy foods	Buy Well – Mobile Food Stores Eat Well
	Lack of access to information and affordable physical activity	Activate London
	Lack of community facilities	Healthy Spaces – Cook Eat Grow Project
	Lack of employment and training	Capacity building Signposting MWIA WLDT

Table 10.3 - Camden

LAA Priorities	Community Café Priorities	Projects Implemented
A sustainable Camden that adapts to a growing population A strong Camden economy that includes everyone A connected Camden community where people lead active, healthy lives A safe Camden that is a vibrant part of our world city	Need for community building	Be Creative Be Well – Banner making, film making, music, festivals, carnivals, performance party
	Youth issues, anti-social behaviours	Activate London – Hip-hop classes for children Youth.com
	Lack of understanding and access to affordable healthy foods locally	Community Feast
	Lack of training and employment opportunities	Capacity building Signposting WLDT

Table 10.4 – Ealing

LAA Priorities	Community Café Priorities	Projects Implemented
Provide efficient, well-run local services Promote cohesive and engaged community Reduce inequalities, promote wellbeing and independence Make Ealing one of the safest places in London Create a great place for every child and young person to grow up in Ealing Make Ealing a better place to live and a thriving place to live and work	Isolation of older people Fear of crime	Establish a local network for information, learning and resources, and build on the activities of key groups WLDT
	Limited access to and lack of affordable healthy foods	Healthy Spaces – Gardening and Community Allotments
	On-going regeneration of South Acton has resulted in significant anxiety and uncertainty among the residents	Be Creative Be Well – Group sessions, Storytelling, Film making workshops, Salsa and Rumba dances (to reduce the negative experiences of the regeneration of South Acton) WLDT
	Limited activities for young people to engage in Anti-social behaviour and drug use among young people High cost of existing services restrict the uptake of physical activities	Activate London – Disco dance classes, African dances, Salsa in the Street, Latin Rumba Therapy, South Acton Walks Be Creative Be Well – Audio-visual media training
	Poor quality of facilities and open spaces on the estate	Healthy Spaces Encourage the use of the Oak Tree Community Centre as a hub in the community

Table 10.5 - Greenwich

LAA Priorities	Community Café Priorities	Projects Implemented
Stronger and more cohesive communities Improve the relative economic health of Greenwich, with a focus on tackling unemployment Affordable, good quality housing for all residents Increase participation by young people aged 16+ in education and training Improve the health and wellbeing of vulnerable children and young people Positive and law-abiding behaviour in and out of school Improve the relative health of the borough and narrow the gap in health outcomes between disadvantaged people and others Improve wellbeing with a focus on mental health and supporting people to live independently Reduce harm caused by alcohol and drug misuse Reduce violence and crime Better, cleaner and greener public spaces Energy efficiency	Need for social cohesion Need for intergenerational activities	Build capacity and cohesion DIY Happiness – Can money buy happiness? Dare to Dream Eat Well – Healthy Eating in Barnfield, Community Feast WLDT – Barnfield after-school club, Intergenerational Creative Arts Workshop
	Fear of young people and growing gang culture	Youth.com – Woolwich Common Youth Centre, Free Media Workshops
	Need for physical activity facilities especially women-specific exercises	Activate London – Women-only gym sessions, Healthy Walks, Let's Get Active (women-only aerobic sessions)
	Need for pride of place and improved physical environment	Improve physical space Community Garden MWIA

Table 10.6 – Hackney

LAA Priorities	Community Café Priorities	Projects Implemented
Successfully tackle educational underachievement Reduce worklessness for 18-24 years old Reduce rate of violent crime and criminal gang culture Reduce health inequalities for children and young people Increase access to low cost home ownership	Need for stronger community cohesion	Events that encourage integration through arts and fun Community Feast
	Disaffected youths	Support local youths Youth.com
	Need for improved food literacy	Buy Well – Food Coop
	Lack of information and knowledge about opportunities available	Signposting and supporting wellbeing by accessing local opportunities Capacity building through education and support WLDT
	Poor built environment and open spaces	Enjoyable utilisation of local green spaces Healthy Spaces Club

Table 10.7 – Southwark

LAA Priorities	Community Café Priorities	Projects Implemented
Children and young people (under-18 conception rate; rate of exclusion from school; education, employment and training)	Community building	Community Feast - build community spirit DIY – Dare to Dream
Employment (reduction of inequalities, education and training) Reduction in health inequalities	Provision of activities and facilities for youths and younger children	Increase level of physical activity Activate London – YMCA young people's football sessions
Cleaner greener environment (emissions; recycling; cleanliness; transportation) Safer environment (community cohesiveness, reduction of violent crimes and re-offenders; domestic violence)	Safety	Promote access to open spaces, and improve mental wellbeing Healthy Spaces – Cossall Estate Community Growing Project
Improved parks and open spaces Housing (access to good affordable housing; reduce homelessness) Enterprise (increase and support active enterprise)	Older residents and isolation	Improve mental wellbeing and promote access to open spaces Activate London – Chair dancing for elderly residents, YMCA chair dancing activity
	Access to affordable healthy foods and food preparation skills	Improve healthy eating choices

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Table 10.8 – Waltham Forest

LAA Priorities	Community Café Priorities	Projects Implemented
Manage population growth and change (improved housing quality and choice; generate jobs; cultivate civic participation, cohesion and independence; respond practically to climate change)

Create wealth and opportunity for residents (provide skills and confidence; full employment; ensure residents are fit and healthy for work)

Retain more wealth in the borough (create vibrant town centres; transform public spaces; improve community safety and reduce anti-social behaviour) | Community cohesion | Events that encourage integration through arts and fun

Be Creative Be Well – Waltham Forest Arts in Education Dance Project, Draw-Out Mobile Drawing Project

Eat Well - Community Feast |
| | Disaffected youths | Support local youths

Youth.com |
| | Lack of information and opportunities | Signposting and supporting wellbeing / assessing local opportunities

WLDT |
| | Lack of capacity, confidence and skills | Capacity building through education and support

WLDT |
| | Poor built environment and open spaces | Enjoyable utilisation of local green spaces

Healthy Spaces – Food growing and plant renovation |

Table 10.9 - Westminster

LAA Priorities	Community Café Priorities	PID
Improve city environment (energy efficiency; recycling; open spaces; reduce anti-social behaviour and violence) Better life chances for all citizens (good affordable housing; healthy lifestyles, good quality of life for older residents and those with long term condition and their carers; support young, vulnerable and disadvantaged people into education, employment and training) Strong, united and engaged communities (pride in community; increase volunteering and community action)	Need for community cohesion and safety	Be Creative Be Well – Quilt of Memories, Queens Park Life Stories DIY Happiness – Dare to Dream Community Feasts
	Lack of diet literacy and access to affordable healthy foods	Buy Well – Food Coop
	Lack of physical activity facilities especially for younger children, elderly residents and women	Activate London – Activate Families, Free dance sessions, Activate Yoga
	Youth issues – anti-social behaviours, gangs, bikes and drugs	Youth.com Be Creative Be Well – Avenue Youth Project
	Lack of employment, training and skills	Be Creative Be Well – Creative writing sessions MWIA WLDT

Chapter 11 – Discussion and Conclusion

11.1. Introduction

This section discusses the results of this study; and examines these in light of earlier theoretical and empirical work on community engagement. It also looks at the strengths and limitations of the study, and discusses their implications for study results.

The study used a multi-method approach to examine and document the process of community engagement in the design and delivery of health promotion interventions in several deprived areas in London. It aimed to identify incentives, challenges and benefits of community engagement as perceived by different community stakeholders; it also assessed whether and how the process of engagement affected the type and number of interventions delivered, and communities themselves.

This study was set within the Well London (WL) programme which delivered health promotion interventions in 20 deprived communities in London following a community engagement process (CEP) which was integral to the programme. The community events examined in this study were the community cafés, community action workshops (CAW) and project implementation workshops (PIM). Data were collected from three groups of stakeholders – community residents, community voluntary groups and the WL alliance partners – through questionnaire surveys, participant observation, qualitative interviews and examination of documents. A literature review was also done to establish existing knowledge of community engagement in health promotion.

Review of academic literature and policies showed that the process of community engagement is generally supported; however many people are not able or willing to contribute to the community engagement processes as they experience barriers which prevent or limit their involvement in the community life. Furthermore, most of the existing literature on community engagement so far has presented evidence of the process of engagement; there is limited evidence of the impact

and outcome of the process (Popay et al., 2007). Where impacts have been reported, they are usually those of the health promotion content associated with the CEP (Swainston & Summerbell, 2008). There is little evidence to show the factors which indicate success or impact of the engagement processes. So, community engagement has been used as a vehicle for delivering health promotion interventions; however only the health promotion intervention and its impact are evaluated and used as the basis for measuring success of intervention. Rarely is the impact of CEP used, measured or evaluated.

11.2. Study Findings and Relationship to Existing Literature

11.2.1. Who Attends Community Engagement Events?

The participants of the community engagement events were similar in many respects to the residents of the Well London areas. However, the café participants seemed to be slightly older than the residents recruited to a representative sample of a household survey which took place in these areas at the same time and which was used in this study for comparative purposes. The level of civic engagement was similar to the findings by Glaser (2001) and Coulthard et al. (2002) where younger residents were least likely to participate in community activities. This may indicate that the younger people are not particularly interested in these types of community events or older people have more social capital and time to attend community activities, as suggested by Lowndes (2004). It is also possible that these and other reported events were organised at the time more convenient for older residents. Younger people may have been at school, training or work at the times the events were scheduled to take place.

Both this study and the WL survey recorded a higher proportion of female participants, however the female/male ratio was found to be higher in this study with three-quarters of the café participants being women. Other studies also found higher levels of participation by women in community events (GEM, 2004; Lowndes, 2004). However, this study also found that as the process moved on to

more formal structures in the CAWs and PIMs, the proportions of female resident participants reduced significantly, which suggests that women do participate in community activities but largely in those of informal type.

This study recorded a higher proportion of participants who were single because they were separated, divorced or widowed than the WL survey. These residents may have looked to these events as a way of coping with loneliness and isolation; or as a way of getting to know more people in their neighbourhood and being social. However, the proportion of those who were 'single and never married' was less than the WL sample. This may be because the participants were generally older and therefore more likely to have been in a relationship or be settled in a relationship.

Both surveys also found an almost equal split between participants born in the UK and those born outside, with a wide range in the length of stay in the UK for those born outside. The participants consisted of new and older immigrants. This suggests that these events were appealing to those born in the UK and those born outside of the UK. There was also an almost equal split between participants who were White and those who said they were of minority ethnicities. However, there are indications that the ethnicity composition of the events varied between the areas as some events had predominantly White participants while others had predominantly non-White participants.

Overall, the average participant in this study had lived almost twice as long as the WL participant in their neighbourhood; indicating that people who had lived longer in a neighbourhood may be more likely to participate in community activities. The average length of stay in the neighbourhood was similar to the UK national (GLF 2009 survey).

Religion did not appear to affect participation in the cafes; however there were some issues with the use of venues associated with certain religious affiliations.

There were some difference in relation to economic activities of café attendees and WL area residents. Thus, the café attendees were less likely to be unemployed; but there were significantly more retired participants. A larger proportion of

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unemployed people in the WL survey may be because the survey provided monetary incentives for participation and this made it more attractive for unemployed people. On the other hand, the low attendance at the cafés by unemployed people may be because they have lost some of their locus of control and do not believe that they can influence things in their lives or neighbourhoods.

Some studies showed that people may attend to gain skills, employment or training (Boyle et al., 2006; Bickerstaff & Walker, 2005; Callard & Friedli, 2005; Attree, 2004; Johnstone & Campbell-Jones, 2003; Del Tufo & Gastner, 2002; Seyfang & Smith 2002: Matthews, 2001; Matarasso, 1997). However this study did not find a correlation with that as fewer unemployed people attended. Previous studies also found that having more free time increased participation (Melhuish, 2005; Carr-Hill, 2003).

In many of the communities, because desk-based research done for the WL programme showed that a large proportion of the residents were unemployed, the delivery partners felt it was acceptable to schedule events for the daytime. It turned out that many of the residents were in paid employment after all, and could not attend events during their working hours. Anecdotal evidence also points to the fact that many residents who were not in paid employment would usually go to the bank or post office during the daytime to collect their benefits, or to their local authorities for administrative reasons.

The café participants were more likely to say that their health was "bad" or "very bad"; and about a third reported having one or more long-term illness or disability, which may explain people's interest in health-focused community events where they felt they could get information and help. However, this study found no difference in relation to the levels of reported happiness.

Significantly fewer café participants reported daily drinking and smoking than the national survey. This was not explored further but an explanation could be that smokers and drinkers are less likely to participate in health-themed community activities, or that people at health-themed community activities were less likely to report their unhealthy lifestyle behaviours.

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The cafe survey found that more respondents had people they could turn to in times of crises. There were more WL respondents who did not have anyone to turn to and who coped with crisis on their own. People who attend community events may be those who already have a good social network and may have even heard about the events through friends or neighbours; they are also more likely to come if they know they will see people they already know at the events. Another explanation could be that because they are already socially connected, they may feel confident to interact with other people. So, it is possible that these cafés did not necessarily attract people who are lonely or isolated; those who attended may be those who are already connected.

More people in the national survey said they were 'very satisfied' or 'satisfied' with their neighbourhoods than the café and WL surveys. The WL areas where the WL and café surveys took place were deprived areas and so the residents are less likely to be satisfied with their neighbourhoods for that same reason

More respondents in the WL areas said they felt 'a bit unsafe' or 'very unsafe' in their neighbourhoods at night, however, twice as many national respondents than the other two surveys said they 'never go out alone when dark'. This may be because those in the WL areas who 'never go out alone' did in fact feel unsafe about going out and therefore did not attend the cafés.

The attendance of the second phase cafés was better than the first phase ones. This might be a result of the increased experience of organising the events and a review of lessons learnt from the first phase. Also in the second phase, the co-hosts and WL leads used a variety of strategies to increase cafe attendance, including organising a raffle draw for every resident who attended the café.

11.2.2. What Stakeholders Thought of the CEP

The three groups of participants in this study generally agreed that the WL CEP was effective and interesting. It provided opportunities for community residents to come together to share ideas and express their community priorities. The WL alliance organisations felt that it was useful and effective in obtaining information from the residents, but believed it could have worked better with more resources

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and time, and better management of resident's expectations. The local community organisations (co-hosts) were particularly fond of the engagement approaches used; they felt it was innovative and could succeed where other methods may have struggled. The residents themselves also thought it was a good process which enabled them voice their concerns and they believed that their views had been heard and would be addressed. Many residents said that the process met their expectations.

The qualitative interview participants who were residents seemed more critical of the cafés and identified less positive aspects than the café survey respondents. Over time, respondents may have become more critical when the feel-good emotions of the café had gone away and their expectations had not been met. Another explanation is that perhaps they felt more relaxed talking about the cafés after some time rather than expressing negative views immediately after the café.

Three-quarters of café respondents said they were likely to participate in future community engagement events. However, very few café participants attended the CAW and PIM that followed. The format of the events might have played a role in residents' participation as respondents might have participated in a similar event such as another café, but not a formal structured community event.

11.2.3. What Made the Well London CEP Successful?

Different stakeholders groups were in agreement about what made the WL CEP successful. The two most important successes were a) bringing the community together in a relaxed informal way which encouraged discussions, debate and sharing of ideas; and b) the innovative approaches used at the café and workshops.

The CEP engendered a sense of community in the WL neighbourhoods, and made the residents feel empowered that they could change their neighbourhoods for the better by getting together, discussing their needs and identifying their priorities. Although, there may have been some uncertainties as to whether there were actually changes due to residents' participation, the key issue is the perceived empowerment of the residents, which Perkins & Zimmerman (1995), Bandura (1989)

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and Kieffer (1984) refer to as psychological empowerment, and which has been shown to be just as important as the actual empowerment. The residents were also demonstrably empowered in many ways. The communities' awareness was raised to health issues in the neighbourhoods; they were able to discuss these issues at the cafés, and take stock of community resources at the CAWs; identify strategies for addressing their priorities; increase their social network and cohesion; and increase access to local services. They were also empowered to hold the delivery organisations accountable for resources and projects. Evidence from this study however points to this empowerment being more of a process rather than an outcome to the CEP.

Many studies found that community events which incorporate the active participation of local residents in the design of interventions are effective in achieving community buy-in into projects delivered. White et al. (2003), for example, reported high levels of participation in community workshops which actively involved local residents, although the workshops in their study ran for two weeks in each community while only one community action workshop was held in each of the WL areas. The level of participation and involvement in the WL projects might have been increased if the workshops had run for a longer period to build more enthusiasm and interest, as the participants complained of time constraints in the workshops. White et al. (2003) found that the workshops in their study not only increased participation but also improved the sustainability of projects and strengthened relationships in the community. They also suggest that these workshops helped engage a wider variety of participants and were highly acceptable to the deprived communities they served (White et al., 2003).

The second important success of the CEP was the World Café and the appreciative enquiry approaches used at the cafés and CAWs. The three groups of participants found these approaches extremely useful. The residents enjoyed the events because it was informal, entertaining, relaxed, and the discussions were primarily driven by them. The approaches were new to the community organisations and they found their involvement to be an invaluable learning experience which they could use in their other projects. The WL partners found the

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approaches useful because of the ease and effectiveness of engaging residents and gathering information.

Some studies reported problems with the use of certain models of engagement (Cole & Smith, 1996) but this study found that the approaches used for engagement were acceptable to the communities and local stakeholders and that the delivery partners found them useful for the purposes of engaging residents and obtaining information to help with the design and delivery of interventions. Therefore, the World Café and appreciative enquiry approaches were effective community engagement models.

For community engagement to be effective and successful, this study found that it is important that delivery organisations spend time getting to know communities and building relationships and trust. Cole et al. (2004) and Gaster & Crossley (2000) also found that the time spent knowing the community was an enabler for the process. Other studies also found that when delivery organisations have a good knowledge and expertise of community development (Hills et al., 2007; Cole & Smith, 1996); a high level of commitment to the process (Hills et al., 2007; Tunstill et al., 2005); and sufficient resources to carry effectively carry out the process (Taylor, 2006), community engagement can be delivered effectively. This study also found that it was important for the delivery organisations to have a shared knowledge of the integral role of community development; and to have sufficient human and financial resources to make the process worthwhile.

Another enabler for community engagement which this study found was the important role of community organisations as an entry into the community. Previous studies found that the right choice of community organisation used as a broker for providing support, training, communication and a visible entry and presence in the community, was important for the success of any CEP (Coxon, 2007; Taylor, 2006; Birchall & Simmons, 2004; Church & Elster, 2002; Hashagen, 2002; Osborne et al., 2002).

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11.2.4. What Motivated Different Stakeholders to Participate in the CEP

The primary motivation for many residents was the desire to belong to a community and be a part of the mechanism that brings about change. There was a strong aspiration for a better community and the residents believed that if they contributed to the process, they could help make this happen. Other reasons for participation are hinged on this; they believed that if they got to know their neighbours, socialised and voiced concerns, they could collectively play a role in making their community cohesive and that their voices would be louder.

This desire to play a role in community was very strongly reflected in people's desire to belong in a community. This study found that residents were motivated by their sense of belonging; both the sense of belonging to a community and the sense that the neighbourhood was theirs. There was a strong sense of pride in the neighbourhood, even when they admitted that there were needs and problems.

Another key motivation was an interest in the issue or theme of the engagement. This study found that some residents attended the events because of their interest in the theme of the events and they wanted to know more about it. Residents also admitted that they were more likely to attend events when they knew that issues of significant interest would be discussed. So, there were examples of using issues such as crime and anti-social behaviour to get the interest of people in areas where these were rampant, and people wanted to put an end to the problems.

Many residents were also motivated by the expectation of having fun and being entertained at the events, and this may account for the differences in residents' turnout at the various engagement events where more people attended the more relaxed and entertaining café. The idea that the events would be interesting and family-friendly also helped motivated people because they felt it was something the whole family could participate in; and participant observation notes confirmed the presence of families at the events.

Many organisations said that they had expectations of financial support by being involved in a programme of the magnitude of WL. There was also the expectation that being involved would give the necessary exposure that would help acquire

more funding from similar sources. The WL was also an opportunity for organisations to practice new community engagement approaches which could be replicated in other programmes.

There is a growing acknowledgement and acceptance of the role of multi-organisational collaboration for health promotion, and many organisations are willing to work together to deliver effective health promotion programmes. However, this study found that many organisations still hold various organisational agendas for their participation; and although there are altruistic reasons of wanting to improve the health of communities, especially the deprived ones, the primary incentive for organisations involved in community engagement for health promotion remain financial.

11.2.5. Challenges of the Well London CEP

The challenges faced in the CEP differed among the different groups. The residents faced physical, institutional, political, personal and collective barriers; some they were able to overcome on their own while others could not be overcome. Many barriers required changes in the socio-economic, environmental, political and cultural determinants which the individual alone cannot change. Barriers to participation are often caused by, and may be perpetuated by socio-economic circumstances of the residents; and the social change required to ease these barriers needs to be addressed using multi-sectoral collaboration in much the same way as addressing the socio-economic determinants of health. However, the effectiveness of community engagement may be undermined when there are unrealistic expectations that one single process will solve a myriad of social problems resulting from inequalities.

An important challenge for the CEP was the continuity of the process in terms of having the same people at the different levels of engagement events. This study found that although many survey respondents indicated that they were likely to participate in similar community events, very few attended the CAWs and PIMs; and many in-depth interviewees did not know about or participate in any projects delivered by the WL programme. In addition, it is not reasonable to say that the

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workshops provided a logical continuum to the cafes because 1) the participants were not the same at both events; 2) they usually had differing opinions; 3) new issues came up at the workshops, and 4) there were usually little or no resident participation at many of the workshops.

Time constraint was a barrier that affected all groups of participants. Timing of the community events and the amount of personal time required to participate in the multi-level engagement process of the WL programme was a barrier for many residents. Butin (2007) found that time-consuming processes could create barriers to engagement. The personal time and effort required to be involved in the multi-layered WL CEP overwhelmed many residents and presented a barrier to their participation. Pargee et al. (1999) found that this barrier resulted in the loss of many previously-engaged residents who could not cope with the amount of time required of them (Pargee et al., 1999).

The organisations all felt time-constrained by the amount of work involved and the speed of the CEP; and this put significant pressure on the human resources available.

This study also found that, similar to previous studies (Hill et al., 2007; Tunstill et al., 2005; Watson et al., 2004; Cairncross et al., 2002), lack of clear communication between the programme delivery organisations and the local stakeholders and residents caused a barrier to engagement. Also, a lack of knowledge of the communities to be engaged resulting in inappropriate timing of events and failure to predict and make provisions for diversity in the community (Hills et al., 2007; Lawless, 2004; Watson et al., 2004; Cole & Smith, 1996; McArthur et al., 1996) was found in this study.

The organisations also faced significant challenges as a result of inappropriately-managed and unmet expectations of the residents. This affected the level of engagement and participation which was felt in the attendance at some projects, and the attitude of residents towards the programme. Several other studies reported barriers resulting from lack of trust in external delivery agencies (Pargee et al., 1999) due to past experiences of unmet expectations (Taylor, 2006; Russell,

2005; Sullivan & Howard, 2005; Barnes et al., 2004; Chouhan & Lusane, 2004; Lawless, 2004). Consultation fatigue reported by Bickerstaff & Walker (2005), Gunn (2005) and Cole et al. (2004) was also found in this study. Many of the WL areas had been consulted several times in the past for various issues including regeneration. They had not always got what they wanted from these consultations and were therefore also apathetic to further consultations. Therefore, the failure to perceive a noticeable change resulting from the consultation process may lead to a resistance by community members to be further engaged (Beresford & Hoban, 2005; Bickerstaff & Walker, 2005; Newman et al., 2004; Barnes et al., 2003).

Other key challenges faced by the organisations were those associated with working with other organisations collaboratively. The coming together of organisations that had little in common other than the planning and delivery of community engagement process and health promotion interventions was always going to be difficult, but the lack of strong leadership made it even more difficult.

Well London organisations were challenged by the choice of community organisations that provided entry into the communities. The choice of co-host sometimes caused more fragmentation in the communities than bringing together, especially where there were already disputes or disagreement between the co-host and other local organisations or groups of residents.

There were also challenges of working in communities that were particularly challenged in terms of their disadvantage, histories of consultations, unsuccessful engagement and relationships with local authorities and agencies, transient populations, local regeneration and politics. The communities proved to be similar only in their deprivation scores; they each presented different challenges and the need for flexibility in adapting the CEP to the different areas was realised.

There was also the challenge of engaging young people in community activities. Many youths are vilified in their communities as troublemakers as the General Household Survey (2000) showed that 30% of respondents felt that teenagers hanging around street corners and their use of alcohol and drugs were problems in their neighbourhoods (Coulthard et al., 2002). This perception affects the

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engagement of youths and creates a barrier. This study found that many residents agreed that the youths were not all bad and that they only needed facilities and things to do to occupy them.

Many studies have reported on barriers such as the external control of decision-making powers and choice of issues to be engaged in (Bolam et al., 2006; Tunstill et al, 2005; Lawless, 2004; Cairncross et al., 2002; McArthur et al., 1996); uncertainties arising from short-term funding for engagement and provision of sustainable projects (Bolam et al., 2006; White et al., 2003; Pargee et al., 1999; Williams & Olano, 1999; Holder et al., 1997); availability of suitable venues for events (Scutchfield et al., 2006; Duncan, 2002; Holder et al., 1997); and local delivery agencies feeling threatened by external ones (Holder et al., 1997) were also found to be true in this study.

Other barriers which were found in this study which were also reported in previous studies include some individuals and groups trying to impose their agendas on the programme and making it out to be the wish of the majority in the community (Holder et al., 1997; Arbeit et al., 1991); and the presence of certain 'usual suspects' who were already engaged and knew how to formally communicate their opinions, and thereby excluded the voices of those who were less skilled in formal communications from being heard (Bickerstaff & Walker, 2005; Newman et al., 2004; Barnes et al., 2003). During the workshops, there was evidence of a small number of individuals and representatives of local stakeholder groups who tried to monopolise the meeting discussions.

11.2.6. How to Effectively Engage Communities – Best-Practice and Lessons Learnt

The WL engagement approach was generally acceptable to all stakeholders. The World Café and appreciative enquiry approaches were particularly useful and effective as the residents enjoyed the events and the organisations were able to get information they needed about the communities. However, there were concerns about the amount of residents' personal time required to be involved in the multi-level process. In addition, as the CEP progressed and the format of the

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events moved from informal to formal, fewer residents generally, and women in particular attended. The residents who attended the more formal-structured meetings were found to be those who were already civically engaged in one way or another.

One of the critical lessons in this study was the importance of managing the expectations of the community residents and local stakeholders by having clear communications early in the process of what is possible and viable within the programme and what the limitations are. This study found that good communication is important between the delivery organisations and the local residents and stakeholders so that the later groups know from the start what the programme is about, what it offers and what the limitations might be.

The multi-organisation collaboration of the WL delivered robust effective health promotion, but was often froth with challenges; and there was need for sufficient time for the alliances to build trust and relationships, and to understand individual organisation priorities and collective shared goals of the programme.

The choice of appropriate co-host organisations that were neutral to local politics, not seen to represent one group over another, and trusted in the community, helped provide seamless entry into the communities and improved the level of residents' participation in the programme.

This study found the importance of choosing the right issue to engage communities on. For some of the WL communities, health was not the "right" issue at the time because residents were feeling unsettled about crime, local politics and regeneration.

This study also emphasised the importance of time; time to research and get to know the community; time to build relationships and trust; time to allow for unforeseen situations; and time to go at the pace of the community. Having sufficient and realistic timescales was the second most important lesson learnt from the CEP. This study found that inadequate time for the CEP processes did not only undermine the impact of CEP, it affected subsequent programmatic activities. Some communities were more engagement-ready than others by reason of

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having existing infrastructure which supported the community such as trusted community organisations and groups. As a result, the communities engaged at different rates but the process ran at similar speeds across the areas and some communities felt left behind.

In addition, the time lapses that occurred between the CEP events and the projects affected the level of enthusiasm and participation. Most residents and local stakeholders had lost their initial enthusiasm and interest when there was a time lag between when they participated in the CEP events and when the projects were delivered, and many could not associate projects with the CEP. There had also been little communication with the residents in this time and so many had moved on to other things and had no expectations of the CEP. Therefore, when the projects were initiated and delivered, the people had to be re-engaged, and not all of them were those who had previously participated in the events.

The next important lesson learnt is the consequence of not having a good entry into the community. Differences in levels of attendance at events, participation, and experiences differed across the areas; and it was easier to work in those areas where there was an organisation that had good relationships and links with the different groups in the community. The choice of a co-host organisation could easily determine the success or failure of a programme. Apathy towards or mistrust of a local organisation was extended to the programme and when the community respected and trusted an organisation, they extend the same courtesies to the programme and its delivery organisations.

Another lesson learnt is the importance of having a good knowledge of the community, as this could have an effect on the attendance of community events. When known and accessible venues were used for events, people felt comfortable going there. There were examples of areas where an unfamiliar and largely unknown venue was used and there was a low turnout of residents. In other areas where the venue was familiar and functional, people turned out in large numbers because it was a venue they visited frequently. Another example of the importance of knowing the community was seen when contrary to desk-based

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research and assumptions that there were high proportions of unemployed people in the target areas, and that it was appropriate to schedule events during the day; this study found that there were higher proportions of residents who were in full time employment or education at the cafés than unemployed residents.

11.2.7. Impact of CEP on WL Communities and Projects

The CEP events helped to bring the community together and raise critical awareness around important issues in the community. The events also raised the expectations of the residents as to what they may get from the programme; although this turned out to be a challenge because it was not properly managed. However, it could have been a positive impact if the expectations were met and the projects delivered timely when the residents were still enthusiastic about the programme.

The impact of the CEP on the design and delivery of the health promotion interventions is inconclusive in this study as documentary and anecdotal evidence point to different effects.

The BLF project bid described that the major expected outcomes of the WL programme in the 20 target areas would include: 1) real and sustainable gains in the health and wellbeing of the communities through the delivery of coordinated grass-root projects which would build capacity; and 2) development of robust, evidence-based models and benchmarks that will influence policy and practice (WL Strategy document, 2007). However, the strategy was unclear as to how the CEP would help achieve these goals as the projects had been by necessity, pre-designed with little or no room for modifications in their fundamental parts. They had to be projects which promoted physical and mental health through the provision of activities that enhanced the quality and quantity of physical activity, healthy eating and mental wellbeing.

The study found that overall the portfolio of interventions designed for each area did address the needs of the local communities. The main target groups within these projects were children and young people, Black and Minority Ethnic (BAME) groups and those suffering long-term conditions. However, to what extent the

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content of the portfolio was influenced by the needs expressed by the communities at the engagement events and to what extent by prior knowledge of these communities, remain questionable.

Further, there was an acknowledgement at the WL programme level that there were variations within and across the target communities, and therefore a variety of the issues they faced. The projects delivered in each target area varied, and there is some evidence to suggest that the number and composition of projects agreed was shaped by the needs identified during CEP. There is also some evidence that the delivery organisations changed various aspects of their projects following the CEP, although by their own admission, these changes had come about after the CEP but not because of it. Others suggest that the CEP had helped the delivery of projects by helping to identify key local stakeholders, but had not changed the design or delivery of projects.

The study found many similarities between the areas' LAAs and WL interventions. It is possible that as both strategies tried to identify the most urgent needs of the communities, the priorities and approaches proposed were similar. Another explanation, however, is that many local delivery organisations were part of the development of their areas' LAAs and were familiar with the needs of their communities which they tried to communicate through the WL CEP (LAAs, café notes, CAW pack). The LAA priorities were also seen as opportunities for WL to build on the existing services and therefore, the congruence between LAAs and WL activities was built into the CEP a priori.

Many studies report the impact of the interventions which have incorporated community engagement. There is limited empirical evidence which report the impact of data related to the effectiveness of the actual CEP, the perceptions of the community relating to the engagement process, and how acceptable the process was to the community (Swainston & Summerbell, 2008; Kagan, 2006). Several studies have found that CEP is effective in the design and delivery of health promotion interventions but this effectiveness is less pronounced when targeting lifestyle behaviour change such as healthy eating (Kumpusalo et al., 1996; Hunt et al., 1993; Arbeit et al., 1991) and physical activity (Pargee et al., 1999;

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Williams & Olani, 1999). Where these impacts are seen, benefits are more likely to be seen on a longer term (Melhuish et al., 2005; ODPM, 2005; Rhodes et al., 2005).

The way that the content of interventions influences the effectiveness of CEP is still uncertain (Swainston & Summerbell, 2008); and it is also unknown how the impact of CEP vary with different population groups (Davidson et al., 1994; Morris et al., 1994; Arbeit et al., 1991).

A number of benefits of CEP in the delivery health promotion interventions have been reported. One of such benefits was a more positive perception of the neighbourhood by the residents (DCLG, 2006; Rhodes et al., 2005; Carr-Hill, 2003; Matarasso, 1997). This study also found a similar benefit where the local residents were taking ownership of communal spaces and taking pride in their neighbourhoods. Other benefits found in this study that have been previously identified include mental wellbeing benefits for participants (Bolam et al., 2006; Boyle et al., 2006; Ziersch & Baum, 2004; Seyfang & Smith, 2002); access to signposting opportunities (Boyle et al., 2006; Attree, 2004; Winters & Patel, 2003; Del Tufo & Gastner, 2002); and improved social networks (Bolam et al., 2006; Boyle et al., 2006; Del Tufo & Gastner, 2004).

Empirical evidence suggest that communities become empowered by CEP (ODPM, 2006; Johnstone et al., 2005; Taylor et al., 2005; ODPM, 2004; Goodlad et al., 2003; Johnstone & Campbell-Jones, 2003; Winters & Patel, 2003) and this was found to be true in this study. By coming together, the communities were empowered to express their needs and to be involved in the process which addressed those needs.

This study did not find evidence of income benefits described by Boyle et al. (2006) nor personal empowerment and increased self-esteem reported by Bolam et al. (2006), Boyle et al. (2006), Attree (2004), Del Tufo & Gastner (2004) and Winters & Patel (2003). However, there was evidence that participants may have acquired some informal transferable skills such as networking, which were also reported by Taylor (2006), Bickerstaff & Walker (2005), Callard & Friedli (2005), McInroy& MacDonald (2005) and Seyfang & Smith (2002).

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A number of authors have found that community engagement can have negative impacts on the communities such as physical, mental and emotional exhaustion (Kagan, 2006; Ziersch & Baum, 2004) and a feeling of disappointment when expectations are not met (Chau, 2007; Bolam et al., 2006). This study found similarly that residents became frustrated and disillusioned when they found out that they were not going to be in total control of the decision-making and resources for the projects delivered.

Another benefit reported in previous studies was an improvement in certain socio-economic indicators such as employment, education, training, income and crime (Rhodes et al., 2005; Carr-Hill, 2003). These benefits are more likely to be seen over a period of time and this study did not find evidence of such benefits.

11.3. Strengths and Limitations of the Study

This study was done under a well-planned and thought-out programme (WL programme) which provided abundant resources and data for empirical study of community engagement in health promotion.

The use of a mixed method approach in this study allowed for triangulation of results from comprehensive and varied data; and allowed for supplemental information to be collected. This approach strengthened the research because the research questions and the different perspectives of the groups involved could be addressed comprehensively.

The study was an evaluation, which measured the extent to which the community engagement process achieved its set goals and objectives. An innovative approach of this research is that it evaluated the process from different perspectives (residents, voluntary organisations and WL delivery partners). The study empirically demonstrates variations in the perception of the engagement process by different stakeholder groups, and showed how important it is to take these different perspectives into account.

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The study draws on the practical experiences of those involved in the engagement and can be helpful for knowledge-sharing and learning. The findings draw attention to what worked in the engagement, and why; which barriers and challenges were experienced and by whom, and how some of these challenges could be overcome. Using the insights into the WL experience, the study presents a set of recommendations for future community engagement events, which adds to the existing body of knowledge and can be used in the development of community engagement policies, guidelines, and planning and implementation tools. The study documented the process of engagement in such a way that it can be replicated in other similar settings with similar resources available.

This study however had a number of limitations which need to be taken into account when interpreting study results. A key limitation was the fact that it was carried out single-handedly by a sole researcher. The result of this was that data collected was limited to how much could be physically achieved by the researcher and the selection of the community events studied was to some extent opportunistic. Furthermore, opportunities to research community events was dictated by the opportunities of the WL programme and therefore this research has the same limitations as any case study research; that is that its findings may be applicable and relevant only to the areas and situations studied here. Community events in other (non-London or non-urban) locations may be very different.

Being a part of a larger project was both a strength and a limitation. There were difficulties when trying to define the boundaries of the research within the much larger complex framework of the WL programme which involved numerous stakeholders, target areas, projects and priorities. It was therefore necessary to focus data collection to specific geographic target areas and to what was achievable within the boundaries of this programme.

This study did not involve those who could not come to the community events, the barriers presented here are either those that the residents experienced but managed to overcome, or those reported by the participants on behalf of non-participants.

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The impacts of CEP described in this study are those reported by the WL partner organisations and co-hosts; and by the limitation of the timing of this study are short-term impacts. Long term impacts could not be measured in this study because it may take years for such impact to be visible.

The interviews took place six to nine months after the cafés and there is the possibility of recall bias. It is also possible that only those residents who had particularly strong (or particularly negative views of the cafés, expressed a wish to take part in the qualitative interviews. This data therefore could be biased by their selective participation.

11.4. Original Contributions to Knowledge

This study contributed to the knowledge of community engagement and its impact on health promotion in a number of ways.

This study documented and evaluated a range of community engagement events, and highlighted the strengths and opportunities, weaknesses and risks inherent in the process. The study is a rare example of a detailed and systematic review of the engagement process which examines it from both descriptive and analytical perspectives.

The study was a primary research which prospectively gathered information using different methods of data collection; sequentially starting with participant observation, followed by the questionnaire and evaluation surveys, qualitative interviews and evidence from programme documents. The use of the mixed methods approach, which has been on the ascendancy in the last decade (Brannen, 2005), allowed an original, eclectic and creative way of addressing a set of complex research questions and added width and depth to the research process. Further, the research undertook a pragmatic approach and used a variety of data collection techniques which could be used complementarily for the purpose of triangulation, and be at the same time integrated in a real life setting.

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The study provided some interesting insights into the problems experienced in the engagement. The researcher found that the most important challenge of community engagement was managing the expectations of community residents, voluntary organisations and local stakeholders. The study showed that it is essential that the communities are clear from the start about what can and cannot be achieved within a programme. This finding has important implications for those who are involved in both community engagement and interventions and suggests how to prevent situations where local communities become disappointed and disillusioned.

The study demonstrates the feasibility and benefits of the World Café model and the Appreciative Enquiry approach for engaging disadvantaged communities living in poorer neighbourhoods. All stakeholders involved in the WL process found the model and approach useful and innovative.

The study provided useful evidence on the socio-demographic characteristics of people involved in community events. It showed that women were more likely to attend informal community engagement events such as the community cafes; it also showed that such events attracted younger and older residents, and people from different ethnic groups. The findings however suggest that participation of specific population groups may significantly vary by area and is heavily dependent on the availability of supporting tools such as interpreters, childcare facilities, disability access and opportunities for entertainment.

The study provided empirical evidence of the benefits of the engagement process for different stakeholder groups. Thus, the residents and local organisations regarded the process of engagement as positive and useful, and believed that it had increased their levels of participation in decision-making, and encouraged changes in their communities. The alliance partners got to know the communities better and were able to identify some local partners and resources. These findings provide evidence to encourage and support the process of engagement and can be used as a useful advocacy tool.

The evidence of the impact on the design and delivery of health promotion interventions was inconclusive in the study. The evidence from documentary

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sources showed that the CEP had modified the type, design and delivery of the WL projects. However, the interviews with local residents and stakeholders suggest that overall the community engagement had little impact on the interventions delivered in the areas. The evidence from the study suggests that the key reason for this may be that many projects had been designed prior to the engagement events with little room for modification. There is a need for further empirical research in this area to measure the impact of the engagement on health interventions and the potential barriers to such impact.

11.5. Conclusions and Recommendations

At the end of this study, the researcher maintains a position of scholarly community health activism. However, my thinking around empowerment, power and community engagement has been deepened and the research to some extent affected my own understanding and position on community engagement, particularly around communities already possessing the power and resources needed to effect desired changes. External organisations "empowering" communities connotes giving them what they already have; instead emphasis should be on supporting them to discover and channel what they already have within.

This study also has psychological undertones because it explores human experiences of social events and situations; and reports subjective perceptions. This study observed a number of community engagement events and examined perceptions of the engagement and its impact by different stakeholders. Most stakeholders involved participated in discussions of the most important community issues, helping local residents to develop attachments to the areas they lived and facilitated interactions between different parties involved in the design and delivery of health promotion interventions.

The community engagement events engaged people of different ages, genders, ethnicities and economic activities. However, it also found that the events seemed to be more popular or more acceptable to women; people who were alone

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because they were divorced, separated or widowed; older residents; and all ethnicities and migrant status.

The key successes of the process were bringing the community together and the use of innovative approaches to engagement of communities.

The CEP challenges included unmet expectations and needs of the community; timing and time constraints; recruitment and continued engagement of residents; continuity of the CEP; ability to engage young residents; finding appropriate entry into community through local community organisations; and dealing with communities which have had unpleasant experiences of past consultations.

The lessons learnt for future processes to be successful include the importance of clear and timely communication with communities; appropriately managed expectations; building in sufficient time for trust and relationship-building; choosing the right co-host organisation; choosing the right issue to engage communities around.

The study found that community participation motivations varied among different stakeholders involved. Factors that motivated residents included the desire to belong to a community; the expectation or desire for change, and the desire to be a part of the vehicle for change; an interest in the issue or theme of engagement; and expectation of fun and entertainment. Voluntary and WL partners got involved primarily for financial reasons and a desire to develop communities.

Barriers to engagement of residents include timing, language barriers, concerns about safety and accessibility, past experiences of consultations leading to a mistrust of external organisations, local politics and regeneration.

The CEP had an impact on all stakeholders involved. For local residents there were positive benefits of socialising and acquisition of skills and information; and negative impacts of frustration and disappointment from unmet expectations and needs. For community organisations and Well London partners, the CEP impacted their organisations and human and material resources both positively and negatively.

The findings about the impact of CEP on health promotion interventions delivered in the target areas were inconclusive, as the opinions of participants varied. There is some evidence to suggest that the CEP changed the portfolio of interventions in the areas in terms of the number, type and combination of the portfolio, as well as the defining the target population for the interventions. However, there was little or no change in the content of the portfolios as they remained interventions targeting physical activity, mental wellbeing, healthy eating, green spaces and arts.

Participants and stakeholders generally believed that the CEP had little or no impact on the design and delivery of the health promotion interventions delivered to the communities because many of the projects were already designed with very little room for modifications. However, they felt that the process was a good one and could be a useful tool for bringing about change in the communities if the communities were given more information and allowed more decision-making and time to decide the projects from the start.

The CEP helped to identify the resources in the communities which could catalyse delivery of projects, as well as becoming aware of those factors which could act as barriers.

From a social constructivist perspective, the researcher believes that every community has its inherent strengths and resources in spite of its present circumstances or past experiences. The community is the expert on its own health needs, priorities and aspirations. The first step in empowering communities is to acknowledge this and to allow them take ownership of local needs, priorities and solutions.

Epistemologically, there were several social constructs and realities going on in the process which may contribute to or hinder empowerment. These realities are sometimes in the background and may not be immediately evident; however they need to be acknowledged because of their impact on change. Therefore, the researcher concurs that empowerment itself is a subjective and relative construct.

The study presents a set of recommendations for future community engagement:

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This study recommends that community engagement ought to involve organisations sharing power and decision-making with the community, rather than ideologically handing over power to the community. This sharing of power is more realistic when it encompasses supporting communities to make the change they want by providing capacity-building opportunities and resources.

The communities and organisations delivering engagement need to work together doing what they know and do better, and taking into account factors that prevent the empowerment of communities, including local politics; dominant groups; inadequate organisational skills and commitment on the part of the community.

Innovative engagement approaches should be part of the policy and practice of community engagement. The approach used should allow for community debate and discussion of issues which are priorities for the residents.

Future policy and practice should set guidelines on the management of expectations and how to communicate programme limitations and goals to the local stakeholders and residents.

Community engagement processes should be adapted in a way that will make participation convenient and appealing for younger residents.

The primary motivation for participation – the desire to belong to a community and help shape the future of that community – should be supported and nurture by community engagement processes. It is important that people engaged know that their participation will make a difference and bring about a change.

Gaining entry into the community need to be through trusted local organisations.

This study also recommends further research into community engagement focusing on the following priorities:

There is still a gap in literature about the barriers faced by those who do not attend community engagement events. It is essential to study the barriers faced by non-participants or those who disengage.

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There is a need to investigate evaluation of community events both immediately after events and over time within a reasonable follow-up period which prevents interference of a significant recall bias but which allows a certain period for people to reflect; and to examine the reasons between the differences in perception, if present.

There is a need for further studies of the impact of community engagement on the content and delivery of health promotion activities. There is also a need for more robust evaluation of the medium and long-term impacts of community engagement on the communities.

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Appendix I – **Well London Projects Portfolio**

The 14 projects delivered by the Well London programme are under two broad groups of projects:

a)   Heart of the Community Projects

b)   Themed Projects

Heart of the Community Projects

These are community-led projects that will deliver community training, consultation and engagement as well as ensure access by all sectors of the community to the theme projects. There are six 'heart of the community' projects, as follows:

1. Consultation, Assessment, Design, Brokerage and Enterprise (CADBE)
    Delivery Partner: University of East London

CADBE informed the design and delivery of the other projects by researching and documenting the state of communities' healthy eating, healthy physical activities and mental wellbeing, and ensuring that Well London projects are tuned to the evolving needs of the communities, as identified by the communities. The community engagement process included community consultative processes (Community Cafés), Appreciative Enquiry Workshops (also called Community Action Workshops) and Project Implementation Meetings, which will inform the portfolio of projects delivered in each super output areas. CADBE is also responsible for the evaluation of the Well London programme.

2. Well London Delivery Team (WLDT)
    Delivery Partner: London Sustainability Exchange (LSx)

This project aims to grow teams of about five volunteers from each of the super output areas (SOAs) drawn from different 'communities of interest', to ensure representation across the communities. This team of volunteers will be trained through another of the Well London projects, 'Training Communities'. Once trained, the WLDT will act as advocates for people, signposting them to services and resources and increasing the responsiveness of local services by engaging with service providers and providing a feedback loop.

3. Youth.comUnity
    Delivery Partner: Central YMCA

This project seeks to ensure that the voices of children and young people are heard in all aspects of Well London's design and delivery of projects, and that they are involved in all

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projects as valued and equal members of the local community. It works alongside schools and youth groups. It also engages young people who are not in employment, education or training, with a view to keeping them off the streets.

4. Active Living Map

   Delivery Partner: Groundwork – London (GW-L)

This project will develop web-based maps for each target LSOAs and will bring together in a single resource, a broad range of wellbeing opportunities and services within easy access of each community. Information ranging from green spaces and parks, physical activities, food co-ops, allotments, farmers markets and other Well London projects will be displayed in a simple accessible format. A paper map will be delivered to households in the target communities via the Well London Delivery Team, General Practice surgeries, community centres, local delivery agents and local authorities.

The web-based maps will be updated quarterly and the paper versions reprinted annually. The map will increase local knowledge and awareness of resources and services; increase opportunities for making healthy eating choices; increase opportunities for and levels of physical activity; create opportunities for employment or volunteering as walk leaders, brokered through CADBE; and create a calendar of Well London events.

The aim of this map is to increase opportunities for making healthier eating choices and levels of physical activities by increasing local knowledge and awareness of resources and services.

5. Training Communities

   Delivery Partner: South London and Maudsley NHS Foundation Trust (SLaM)

This project will coordinate, develop and commission training for community members on behalf of all the Well London projects. It is based on investing in the capacity of the local community to develop and deliver projects expressed as wishes throughout the consultation process. Besides training and personal development resources that support and enable the other Well London projects, it will also be a key agent for ensuring sustainability through creation of pathways of training, employment and social enterprise for local service delivery. It will deliver practical (fitness, exercise or sports leadership, food activators, digital media skills and horticulture and design) and process (Mental Wellbeing Impact Assessment, negotiation and communication, evaluation, community development, consultation facilitation) skills.

6. <u>Wellnet – Well London Learning Network</u>
   <u>Delivery Partner: London Sustainability Exchange (LSX)</u>

This project sets up and supports a wellbeing-focused learning network for communities and professionals. Health information and news about new insights from the Well London programme and other programmes across London will be highlighted and shared with the communities and their Borough Councils and Primary Care Trusts.

Themed Projects

Themed projects are those projects that are focused on the Well London themes of mental health (MH), physical activities (PA) and healthy eating (HE), as well as healthy open spaces and arts and culture. In other words, they are theme-specific and address and improve access to physical activities, healthy eating, mental wellbeing, healthy spaces and arts in the communities. There are eight of these projects.

1. <u>Activate London</u>
   <u>Delivery Partner: Central YMCA</u>

The project aims to improve existing physical activities and encourage participation in new healthy physical recreational activities. These will be done in innovative ways using a range of approaches that ensures inclusion of all age groups, gender and cultural affiliations, ensuring that fun is had by all.

Activities will include healthy walks programmes for different abilities, community football games, yoga, street games, circus skills and much more. The project will also improve accessibility to existing recreational activities by helping to signpost residents to available opportunities. Recruitment and training of Health Activators and Peer Activators from the local communities will provide transferable skills acquisition by local residents.

2. <u>Buy Well</u>
   <u>Delivery Partner: London Sustainability Exchange (LSX)</u>

This project will make it easier for people in the target lower super output areas to buy and eat good quality, affordable, culturally appropriate and healthy foods. Buy Well will support organisations and individuals to introduce healthier options on the menus of local restaurants and shops, and at home. The project will set up and expand the role of community-led food co-ops as social enterprise to improve access to healthy foods, mental health and physical activities-related services.

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Buy Well links closely to Eat Well, Training Communities and the Well London Delivery Team projects.

3. Eat Well
   Delivery Partner: London Sustainability Exchange (LSX)

Eat Well project aims to increase the uptake of healthy food choices and build a sense of community by raising awareness of how a healthy diet promotes good physical and mental wellbeing, making healthier foods more attractive and easier to prepare, and generally celebrating food.

Under the Eat Well project, there will be schemes like the 'Cook and Eat', 'Community Feasts' and training of members of the community to facilitate the food schemes to ensure sustainability. Cultural diversity will also be celebrated by highlighting healthy foods from various cultures.

The 'Buy Well' and 'Eat Well' projects will be delivered either separately or together, according to the needs of the communities.

4. Changing Minds
   Delivery Partner: South London and Maudsley NHS Foundation Trust (SLaM)

This project works by recruiting and training local people with direct experience of mental ill health to deliver mental health awareness training in LSOA communities, empowering people to use their experiences to help reduce the stigma and discrimination faced by many people with mental health problems and promote understanding of mental health and wellbeing. This will also create employment opportunities for people with mental health problems.

The project challenges the negative attitudes and misconceptions experienced by people with mental health problems; increases public understanding of mental health and well-being; and creates opportunities for employment for people with histories of unemployment as a result of mental ill health.

5. DIY Happiness
   Delivery Partner: South London and Maudsley NHS Foundation Trust (SLaM)

The project will empower communities to gain more control of their mental wellbeing and take positive action to address the specific challenges they face. This will be done by providing DIY Happiness kits and organising 'Dare to Dream' awards; as well as working with local theatre groups to develop the 'Can Money Buy Happiness?' play. The project

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will invest time, money and expertise to support people individually and collectively, in exploring their existing strengths to encourage creative problem-solving and thereby improve mental wellbeing.

DIY Happiness will use humour, creativity and evidence emerging from the field of positive psychology to provide practical advice and information that will increase people's ability to 'bounce back' from adversity, reduce both the physical and the psychological impact of stress, increase resilience, and build durable personal resources.

DIY Happiness and 'Dare to Dream' workshops will take place in the target communities over a period of six to eight weeks to help and support people in the community to develop ideas in order to bid for available fund in the project which they can use to make their family, friends and community happier e.g. 'Can money buy women happiness?' workshops.

6. Mental Wellbeing Impact Assessment (MWIA)
    Delivery Partner: South London and Maudsley NHS Foundation Trust (SLaM)

MWIA enables stakeholders to identify the potential impacts on mental wellbeing of their projects. It will help in formulating an action plan to maximise positive and minimise negative impacts. The project will support and train local people from each lower super output area to undertake MWIAs. The project will engage communities and increase understanding of mental wellbeing.

7. Healthy Spaces
    Delivery Partner: Groundwork London (GW-L)

Healthy Spaces recognises the importance of quality and structure of local environments in encouraging people to become healthier and more active in sport. Healthy Spaces is underpinned by evidence which shows that the natural environment can offer many health benefits. Improving and caring for the natural environment through active gardening, gardens for pleasure, or for exercise can enhance wellbeing in the short and long term. (Eco Therapy – Mind 2007).

This project aims to make open spaces around residential, shopping and school areas safe communal spaces which will foster community spirit and cohesion. Residents will be encouraged to participate in health-enhancing activities that promote mental well being, as well as incorporating healthy physical activities.

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Within this project, existing and newly created infrastructure will be used as locations for community gardening and allotments, healthy walk schemes, community art projects and play areas. Involvement in these activities will foster friendship amongst the residents, as well as creating employment opportunities for the local residents (Well London, 2007).

8. Be Creative, Be Well
    Delivery Partner: Arts Council England – London (ACE-L)

The theme of this project is culture and tradition and will engage communities and individuals with the use of arts and cultural activities. There will be as many as 60 tailor-made projects, designed in response to and led by the needs assessment of and consultation with the communities. The use of art will be used to promote healthy eating and living, and improve employability and self-confidence. This project will broker relationships between communities and experienced professional artists. Each project will be tailor-made in response to the needs of communities.

'Be Creative Be Well' project would increase opportunities for community networking and bonding through intergenerational and reminiscence projects, particularly those which promote greater community understanding; improve the mental, emotional and spiritual state of individuals by increasing social networks with uplifting and collaborative projects, building on local community traditions and cultures such as choirs and sewing work; improve community spaces by commissioning public art or engaging communities in arts activity themselves to improve the built environment with e.g. mosaics and graffiti projects; increase physical activity through dance and drama; and provide opportunities for celebratory community events and showcases (Well London, 2007).

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Culture and tradition

Arts Council England works to get more art to more people in more places. We develop and promote the arts across England, acting as an independent body at arm's length from government. We believe that the arts have the power to change lives and communities, and to create opportunities for people throughout the country.

Open spaces and environment

Groundwork London supports communities in need, working with partners to help improve the quality of people's lives, their prospects and potential and the places where they live, work and play. Our vision is of a society of sustainable communities which are vibrant, healthy and safe, which respect the local and global environment and where individuals and enterprise prosper.

Physical activity, young people and children

Central YMCA - is the UK's leading activity for health charity and is also the world's first YMCA, established in 1844. Our objectives are to improve the health and quality of life of individuals and communities; champion the benefits of health-based activity for all; and address, and tackle, health inequalities within our society.

Healthy eating

London Sustainability Exchange (LSx) aims to accelerate the transition to a sustainable London by connecting and motivating people. They work in partnership with business, government and the voluntary and community sector to help overcome barriers to sustainable development in London.

Mental well-being

SLaM provides mental health and substance misuse services for people living in the London Boroughs of Croydon, Lambeth, Southwark and Lewisham. In addition, the Trust provides substance misuse services for people in the London Boroughs of Bromley, Greenwich and Belly, as well as specialist services to people from across the UK.

Research and evaluation

UEL is a global learning community, with 20,000 students from over 120 countries world-wide. Our vision is to achieve recognition, both nationally and internationally, as a successful and inclusive regional university proud of our diversity, committed to new modes of learning which focus on students and enhance their employability, and renowned for our contribution to social, cultural and economic development, especially through our research and scholarship. We have a strong track-record in widening participation and working with industry.

Appendix III – **Well London Logo and Website Address**

Well London website:

INSTITUTE FOR HEALTH AND HUMAN DEVELOPMENT

Well **London**

Communities working together
for a healthier city

UEL
University of
East London

Questionnaire Number	

1. About you

Q1.1 Date of birth

a. Year [   ]   b. Month [   ]   c. Prefers not to say [ ]

Q1.2 Gender

a. Man [ ]   b. Woman [ ]

Q1.3 Place of birth

a. UK [ ]   b. Other country [ ]   Please, specify [   ]

c. Prefers not to say [ ]

Q1.4 How long have you lived in the UK? Please tell me the number of years and (if you can remember) the number of months.

a. Years [ ]   b. Months [ ]   c. Prefers not to say [ ]

Q1.5 – Post code [   ]

Q1.6 To which of the groups listed below do you consider you belong?   [tick ONE option only]

a. White British   j. Chinese

b. White Irish [ ]   k. Other Asian background [ ]

c. Other White background [ ]   l. Mixed White and Black Caribbean [ ]

d. Black (or Black British) Caribbean [ ]   m. Mixed White and Black African [ ]

e. Black (or Black British) African [ ]   n. Mixed White and Asian [ ]

f. Other Black background [ ]   o. Other mixed background [ ]

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g. Asian (or Asian-British) Indian ☐   p. Other ethnic background ☐

h. Asian (or Asian-British) Pakistani ☐   q. Prefers not to say ☐

i. Asian (or Asian-British) Bangladesh ☐

Q1.7 Which of these on this card describes your marital status? [tick ONE option only]

a. Single, (never married) ☐   d. Divorced ☐

b. Married/living with spouse/partner ☐   e. Widowed ☐

c. Separated (but still legally married) ☐   f. Prefers not to say ☐

Q1.8 What is your first language? [_____]

Prefers not to say ☐

Q1.9 What is the highest level of education completed?

     a. Primary ☐

     b. Secondary ☐

     c. Higher (university) ☐

     d. Prefers not to say ☐

Q1.10 What is your religion? [_____]

a. Doesn't practice any religion ☐   b. Prefers not to say ☐

Q1.11 How would you best describe your current employment status? [tick ONE option only]

a. Working in a paid job (30+ hours) ☐

b. Working in a paid job (8-29 hours) ☐

c. Working in a paid job (Less than 8 hours) ☐

d. Self employed ☐

e. Not in paid employment/looking after house or home ☐

f. Full time student at school ☐

g. Full time student at university/polytechnic/college ☐

h. Unemployed ☐

i. Retired from paid employment ☐

j Unable to work due to illness/disability ☐

k. Prefers not to say ☐

2. Your health

Q2.1 Over the last 12 months would you say your health on the whole has been:

a. Good ☐   b. Fairly Good ☐   c. Not Good ☐   d. Bad ☐   e. Prefers not to say ☐

Q2.2 Are you a daily smoker?   a Yes ☐   b. No ☐   c. Prefers not to say ☐

Q2.3 Do you drink alcohol daily?   a. Yes ☐   b. No ☐   c. Prefers not to say ☐

Q2.4 Would you like to do more physical activity than you currently do?

a. Yes ☐   b. No ☐   c. Prefers not to say ☐

Q2.5 If you answered 'yes' could you tick the main reason that you do not do as much physical activity as you would like? [Tick ALL that apply]

a. Too Busy ☐   k. Sessions/clubs are too busy ☐

b. Health reasons ☐   l. Lack of transport ☐

c. No one to do it with ☐   m. I'm too tired ☐

d. Wouldn't enjoy it ☐   n. No facilities near my home ☐

e. Fear of injury ☐   o. No adequate support for my disability ☐

g. Never occurred to me ☐   p. I just can't be bothered ☐

g. Costs too much ☐   q. Not enough information on what's available ☐

h. Special religious/faith requirements ☐   r. Can't be bothered with having to redo my

i. Would feel uncomfortable/out of place ☐   hair/make-up ☐

j. Don't want the commitment (e.g. ☐   s. Other Reason ☐ (Specify :_____)

   club would want too much of my time ☐   t. Prefer not to say ☐

Q2.6 Taking all things together, would you say you are:

a. Very happy ☐   b. Not at all happy ☐ c. Quite happy ☐

d. Not very happy ☐   e. Don't know ☐   f. Prefers not to say ☐

Q2.7 Have you ever been diagnosed with any of the following: [Tick ALL that apply]

a. Heart Condition ☐   f. Respiratory/breathing problems ☐

b. Diabetes ☐   g. Walking difficulties ☐

c. Skin problems ☐   h. High blood pressure/hypertension ☐

d. Tuberculosis ☐   i. Depression ☐

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e. Arthritis ☐   j. Anxiety   ☐

k. Prefers not to say ☐

Q2.8 How much influence do you think people can have on their own health, by the
      Way they choose to live their lives?

a. A lot   ☐

b. A little   ☐

c. None at all   ☐

d. Don't know   ☐

Q2.9 Do you feel there is anything you can do to make your own life healthier?
      a. Yes ☐   b. No ☐   c. Don't know ☐

Q2.10 In the last year, have you tried to make any of the following changes in your

lifestyle to improve your health, even if only for a short time?

☐ Cut down or stop smoking

☐ Cut down on the amount of alcohol I drink

☐ Increase the amount of exercise I take

☐ Control weight

☐ Eat more fruits and vegetables

☐ Eat more healthily

☐ Reduce level of stress

☐ Don't know

☐ None of these

Q2.11 Would you like to eat more healthy foods?

a. Yes ☐   b. No ☐   c. Prefers not to say   ☐

Q2.12 If YES could you indicate the main reason why you feel you cannot eat more

healthily? [Tick only ONE option]

a. Family discouraging or unsupportive   ☐

b. Friends discouraging or unsupportive   ☐

c. People at work discouraging or unsupportive   ☐

d. Not knowing what changes to make   ☐

e. Not knowing how to cook more healthy foods   ☐

f. Poor choice of healthy foods in canteens or restaurants ☐

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g. Poor choice of healthy foods in places where you shop ☐

h. Healthy foods are too expensive ☐

i. Healthy foods take too long to prepare ☐

j. Healthy foods too boring ☐

k. Lack of will power ☐

l. Don't like the taste/don't enjoy healthy foods ☐

m. Don't know ☐

n. None of these ☐

o. Other (Specify :_____) ☐

p. Prefers not to say ☐

Q2.13 Do you have a special diet, like?

☐ Vegetarian

☐ Gluten-free

☐ Hindu

☐ Kosher

☐ Low fat

☐ Low salt

☐ Vegan vegetarian

☐ Other _____

☐ None

Q3. You and your community

Q3.1 In the last 12 months have you:

☐ Attended a public meeting or rally?

☐ Taken part in a public demonstration or protest?

☐ Signed a petition?

☐ None of the above

Q3.2 In the last 12 months, have you taken part in a consultation about services or problems in your local area in any of the following ways?

☐ Completing a questionnaire

☐ Attending a public meeting

☐ Being involved in a group set up to discuss local services or problems in the local area

☐ None of these

Q3.3 Please tell me how much you agree or disagree with the following statements;

Q3.3.1 You can influence decisions affecting your local area

    ☐ Definitely agree

    ☐ Tend to agree

    ☐ Tend to disagree

    ☐ Definitely disagree

    ☐ Don't know

Q3.3.2 You can influence decisions affecting London

    ☐ Definitely agree

    ☐ Tend to agree

    ☐ Tend to disagree

    ☐ Definitely disagree

    ☐ Don't know

Q3.3.3 – You can influence decisions affecting Britain

    ☐ Definitely agree

    ☐ Tend to agree

    ☐ Tend to disagree

    ☐ Definitely disagree

    ☐ Don't know

Q3.4 How satisfied or dissatisfied are you with this neighbourhood as a place to live?

a. Very satisfied ☐   b. Satisfied ☐   c. Neither satisfied nor dissatisfied ☐

d. Very dissatisfied ☐   e. No opinion ☐ f. Prefers not to say   ☐

Q3.5 How safe do you feel generally when you are walking outside alone in this neighbourhood during the daytime?

a. Very safe   ☐   b. Fairly safe   ☐   c. A bit unsafe   ☐

d. Very unsafe   ☐   e. Never out alone ☐   f. Prefers not to say   ☐

Q3.6 And how safe do you feel when you are walking outside in this neighbourhood alone after dark?

a. Very safe   ☐   b. Fairly safe   ☐   c. A bit unsafe   ☐

d. Very unsafe   ☐   e. Never out alone ☐   f. Prefers not to say   ☐

4. About the Community Café

Q4.1 How did you hear about the community café?

    _____

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Q4.2 Were there any barriers to you coming to the café today?

    Yes ☐   No   ☐   Don't Know ☐

Q4.2.1 What is/are the barrier(s)?

    _____

    _____

    _____

Q4.2.2 How did you overcome this/these barrier(s)?

    _____

    _____

    _____

Q4.3 How much did the café meet your expectations?

    Completely ☐   Fairly   ☐

    A lot   ☐   Not at all   ☐

Q4.4 Do you think your concerns have been heard and will be addressed?

☐ Yes, completely   ☐ Fairly

☐ Yes, a lot   ☐ No, not at all

☐ Don't know

Q4.5 How likely are you to participate in a similar event in the future?

☐ Very likely   ☐ Unlikely

☐ Likely   ☐ Very unlikely

☐ Don't know

Well **London**

Communities working together
for a healthier city

Questionnaire Number	

Dear Participant,

You are invited to answer a few questions about this community consultation, what you liked or disliked. We are also asking you some information about yourself, your health and general wellbeing. This information will help us to better understand the needs of the local communities and to make the projects in this area more effective and community-focused. All information you give us here will be strictly confidential and used for the purpose of this project only. We do not pass this information to any other third person or organisation.

Please answer the questions below by ticking the box, which applies to you.

1. About you

1.1 What was the year and month of your birth?

Year ☐   Month ☐
Prefer not to say ☐

1.2 Your gender (please mark as appropriate)

Male	
Female	

1.3 Which country were you born?

a. UK	
b. Other Country (please, specify)	
c. Prefer not to say	

If your response to Question 1.3 is UK'', skip to Question 1.5

1.4 How long have you lived in the UK (if not born in UK)? ☐

1.5 What is your post code? ☐

1.6 Which of these describes your marital status?

a. Single, (never married) ☐   d. Divorced ☐

b. Married/living with spouse/partner ☐   e. Widowed ☐

c. Separated (but still legally married) ☐   f. Prefers not to say ☐

1.7 To which of the groups listed below do you consider you belong?

a. White British		h. Other Asian background	
b. Other White background		i. Mixed White and Black	
c. Black (Black British) Caribbean		j. Mixed White and Asian	
d. Black (Black British) African		k. Other Mixed background	
e. Other Black background		l. Other ethnic background	
f. Asian (Asian British)		m. Prefer not to say	
g. Chinese		n. Don't know	

1.8 What is your first language? ☐

Prefer not to say ☐

1.9 What is your highest level of education completed?

a. Primary ☐

b. Secondary (GCSE) ☐

c. Further ('A' Level) ☐

d. Higher (university) ☐

e. Prefer not to say ☐

f. Other (please specify) ☐

1.10 What is your religion? ☐

a. Do not practice any religion ☐
b. Prefer not to say ☐

1.11 How would you best describe your current employment status? [*tick one option only*]

a. Working in a paid job – Full time	
b. Working in a paid job – Part time	
c. Self-employed	
d. Not in paid employment/ Looking after home	
e. Unemployed	
f. Student	
g. Retired from paid employment	
h. Unable to work due to illness or disability	
i. Full time/ Part time Carer	
j. Prefer not to say	
k. Other (please specify)	

2. Your Health and Wellbeing

2.1 Over the last 12 months, how would you say your health on the whole has been?

a. Very good ☐   b. Good ☐   c. Fair ☐   d. Bad ☐
e. Very bad ☐   f. Prefer not to say ☐

2.2 Have you ever been diagnosed with any of the following: [Tick ALL that apply]

a. Heart Condition ☐   f. Respiratory/breathing problems ☐

b. Diabetes ☐   g. Walking difficulties ☐

c. Skin problems ☐   h. High blood pressure/hypertension ☐

d. Tuberculosis ☐   i. Depression ☐

e. Arthritis ☐   j. Anxiety ☐

  k. Prefer not to say ☐

2.3 Do you feel there is anything you can do to make your own life healthier?

a. Yes   b. No ☐   c. Don't know ☐

2.4 List three things you think you can do to make your own life healthier:

➢ _____ _____
➢ _____ _____
➢ _____ _____

2.5 Do you have any longstanding illness, disability, infirmity or mental health problem which limits your daily activities?

a. Yes
b. No
c. Prefer not to say

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

2.6 On the whole, would you say you are:
a. Very happy ☐   b. Not at all happy ☐   c. Quite happy ☐

d. Not very happy ☐   e. Don't know ☐   f. Prefers not to say ☐

2.7 Who would you look to for help in a time of crisis?
a. Cope on your own   ☐
b. A professional (e.g. doctor, lawyer, health visitor) ☐
c. Church or Faith group   ☐
d. A neighbour   ☐
e. A family member   ☐
f. A friend   ☐
g. Others   ☐   *Please state*   ┌──────────────┐

3. You and Your Community
3.1 How long have you lived in your neighbourhood?   ┌──────────────┐

3.2 How satisfied or dissatisfied are you with this neighbourhood as a place to live?
a. Very satisfied ☐   b. Satisfied ☐   c. Neither satisfied nor dissatisfied ☐
d. Very dissatisfied ☐   e. No opinion ☐ f. Prefers not to say ☐

3.3 How safe do you feel generally when you are walking outside alone in this neighbourhood during the daytime?
a. Very safe   ☐   b. Fairly safe ☐   c. A bit unsafe ☐
d. Very unsafe   ☐   e. Never out alone ☐   f. Prefers not to say ☐

3.4 And how safe do you feel when you are walking outside in this neighbourhood alone after dark?
a. Very safe   ☐   b. Fairly safe   ☐   c. A bit unsafe ☐
d. Very unsafe   ☐   e. Never out alone ☐   f. Prefers not to say   ☐

3.5 In the last 12 months have you: [*TICK ALL THAT APPLIES*]

☐ Attended a public meeting or rally?
☐ Taken part in a public demonstration or protest?
☐ Signed a petition?
☐ Completed a questionnaire?
☐ Attended a public meeting?
☐ Be involved in a group set up to discuss local services or problems in the local area?

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

☐Contacted a local councillor, Member of Parliament or public/ council official?
☐Boycotted certain products for political, ethical or environmental reasons?
☐ None of the above

3.6 Do you belong to, participate in, donate money to or do voluntary work for any of the following groups or organisations? [*TICK ALL THAT APPLIES*]
☐Sports club / club for outdoor activities
☐Trade Union
☐An organisation for humanitarian aid or human rights
☐A religious organisation
☐A political organisation
☐A social club for the young / retired / elderly / women
☐Neighbourhood / Homeowners / Tenants Association
☐Nationality or racial group
☐Self-improvement / Self-help group
☐Any other voluntary organisation
☐None of the above

4. About the Community Café

4.1 How did you hear about the community café?

_____

4.2 Why did you attend the café?

_____
_____

4.3 Were there any barriers to you attending the café today?
a. No ☐
b. Yes ☐
c. Prefer not to say ☐

If your response to question 4.3 "No", skip to Question 4.6

4.4 What (if any) were the barriers to attending the café today?
_____
_____

4.5 How did you overcome this barrier(s)?
_____
_____

4.6 How much did the café meet your expectations?
   a. Completely ☐
   b. A lot ☐
   c. Fairly ☐
   d. Not at all ☐

4.7 Do you think your concerns have been heard and will be addressed?
   a. Yes, completely ☐
   b. Fairly ☐
   c. No, not at all ☐
   d. Don't know ☐

4.8 What do you think about the exhibition and the information contained in it?
   ➢ _____
   ➢ _____
   ➢ _____

4.9 What was good about the community café?
   ➢ _____
   ➢ _____
   ➢ _____

4.10 What would you change about the cafe to make it better?
   ➢ _____
   ➢ _____
   ➢ _____

4.11 How can the community be made more involved in decisions and activities in the neighbourhood?
   ➢ _____
   ➢ _____
   ➢ _____

4.12 Where do you get your information concerning activities and events in your community from?
   ➢ _____

4.13 How likely are you to participate in a similar event in the future?

   a. Very likely ☐   b. Unlikely ☐   c. Likely ☐

   d. Very unlikely ☐   e. Don't know ☐

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

The researcher may like to collect additional information and to discuss some of the issues further with you, for research purposes.
Would you be willing to be contacted?

☐Yes, my details are: Name: _____

Address: _____

_____

Telephone: _____

☐No, thanks

Questions were extracted from the following sources;
http://qb.soc.surrey.ac.uk/surveys/citizenship/pdf
http://qb.soc.surrey.ac.uk/surveys/citizenship/05questcs.pdf
http://qb.soc.surrey.ac.uk/surveys/bsa/05mainqbsa.pdf
http://qb.soc.surrey.ac.uk/surveys/heps/-5mainqheps.pdf
http://qb.soc.surrey.ac.uk/surveys/citizenship/01%20quest.pdf

European Social Survey (ESS)
Home Office Research Study 289, 2003 Home Office Citizenship Survey: People, Families and Communities

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

Well **London**

Communities working together
for a healthier city

Questionnaire Number	

Dear Participant,

You are invited to answer a few questions about this community consultation, what you liked or disliked. We are also asking you some information about yourself, your community or organisation. This information will help us to better understand the needs of the local communities and to make the projects in this area more effective and community-focused. All information you give us here will be strictly confidential and used for the purpose of this project only. We do not pass this information to any other third person or organisation.

Please answer the questions below by ticking the box, which applies to you.

Section 1. About the Community Action Workshop

1.1 How did you hear about the workshop?

1.2 Why did you attend the workshop?

_____

1.3 Were there any barriers to you attending the workshop today?
  d. No ☐
  e. Yes ☐
  f.   Prefer not to say ☐

If your response to question 1.3 "No", skip to Question 1.6

1.4 What (if any) were the barriers to attending the café today?

1.5 How did you overcome this barrier(s)?

1.6 How much did the workshop meet your expectations?
   - e. Completely ☐
   - f. A lot   ☐
   - g. Fairly   ☐
   - h. Not at all   ☐

1.7 Do you think what was discussed at this meeting reflects the views of the community that you represent?
   - e. Yes, completely ☐
   - f. Fairly   ☐
   - g. No, not at all   ☐
   - h. Don't know   ☐

1.8 What was good about the community action workshop?
   - ➢ _____
   - ➢
   - ➢ _____
   - ➢
   - ➢ _____

1.9 What would you change about the workshop to make it better?
   - ➢ _____
   - ➢
   - ➢ _____
   - ➢
   - ➢ _____
   - ➢
   - ➢ _____

1.10 Did you attend the community café held in your area a few weeks ago?

   Yes ☐   No ☐

   If "No", please go to question 1.12

1.11 Do you think that what was discussed today gives a true reflection of the issues raised at the community café?

   Yes ☐   No ☐

1.12 How likely are you to participate in a similar event in the future?
   - a. Very likely ☐   b. Likely ☐   c. Unlikely ☐
   - d. Very unlikely ☐   e. Don't know ☐

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Section 2. About you

2.1 Are you:

A resident	
Representing an organisation	
Other (please specify)	

If you are a resident, please continue to question 2.2

If you represent an organisation, please go to Section 3

2.2 Your gender (please mark as appropriate)

a. Male	
b. Female	

2.3 What is your first language?

Prefer not to say ☐

2.4 How long have you lived in your neighbourhood?

years

2.5 How satisfied or dissatisfied are you with this neighbourhood as a place to live?

a. Very satisfied ☐   b. Satisfied ☐

c. Neither satisfied nor dissatisfied ☐

d. Very dissatisfied ☐   e. No opinion ☐

f. Prefer not to say ☐

2.6 Do you have any longstanding illness, disability, infirmity or mental health problem which limits your daily activities?

d. Yes ☐

e. No ☐

f. Prefer not to say ☐

Section 3 – Representatives of Organisations

3.1 What organisation do you represent?

Local Authority	
Primary Care Trust	
Community Voluntary Organisation	
Other (please specify)	

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

3.2 How is the Well London community engagement process beneficial to your organisation?

_____

_____

3.3 How do you think this community engagement process could be beneficial to the community?

_____

_____

3.4 What is your role or post in your organisation?

_____

Thank you

The researcher may like to collect additional information and to discuss some of the issues further with you, for research purposes.
Would you be willing to be contacted?
☐Yes, my details are: Name: _____

Address: _____

_____

Telephone: _____

☐No, thanks

Appendix VII – **Well London Partners' and Co-hosts' Evaluation Questionnaire**

<u>Well London Alliance Partners' Evaluation of the Community Engagement Process of Well London Phase 1.</u>

1. How would you generally rate the Community Engagement process in the first phase of the Well London Programme?

2. What was good about the CEP for your organisation?

3. How do you think the CEP was/could be beneficial to the community?

4. What problems or barriers (if any) did you encounter during the process of community engagement? How did you overcome the problem(s) or barrier(s)?

5. How will the expressed needs of the community from the CEP shape the delivery of your projects?

6. How do you propose to continue the CEP with the borough(s) you lead on?

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

Appendix VIII – **Qualitative Interviews Topic Guides**

Evaluation of Community Engagement on the Design and Delivery of Health Promotion Interventions

Topic Guide for Interviews with Community Members (Cafe Participants)

Introduction

Aims of the study and how information will be used

Consent form

Questions

1. What were the advantages you derived from being involved in the community engagement process (attending the community café)? What were the disadvantages?

2. What other methods have been used in the past to engage your community and why have they worked or failed?

3. What are the incentives that would encourage you to participate in the future?

4. What differences (positive or negative) have you noticed in your community since the *Well London* programme came into your community?

5. What projects do you know of that have been put in place by the *Well London* programme in your community?

6. How do you think these projects have addressed the issues discussed at the community café?

7. What *Well London* projects have you participated in since the community café? Or what project do you know that any member of your family or your neighbours have participated in?

8. In what way can the *Well London* engagement team continue to communicate with you or keep you informed and engaged?

9. How can the community be engaged in a way that makes them feel empowered and in control of the projects?

10. In what way has the community engagement process benefited or promoted your health and wellbeing? What other benefits have you derived which may not directly be associated with the projects?

11. What do you think are some of the factors that prevent people from being fully engaged in community activities? What are the characteristics of the people who engage in the community?

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

12. Has there been any changes to the way you view or think about healthy eating / physical activities / mental wellbeing since you attended the community café or workshop?

13. Finally, are there any other comments you would like to make about the community engagement process?

- Do you know of any of your neighbours who did not attend the cafe? Can you introduce one of them whom you think might be interested in being similarly interviewed?

<u>Evaluation of Community Engagement on the Design and Delivery of Health Promotion Interventions</u>

<u>Topic Guide for Interviews with Community Voluntary Organisations and Co-Hosts</u>

Introduction
Aims of the study and how information will be used
Consent form
Role in organisation
<u>Questions</u>

1. How has the community engagement process influenced your organisational thinking towards community engagement?

2. How has the community engagement process modified the structure and function of your organisation?

3. How does the Well London community engagement process differ from the engagement process that your organisation normally operates?

4. How do you propose to continue the process of community engagement in the community for which you are co-host, as relates to *Well London*?

5. What do you identify as challenges in the community engagement process? How were they / how can they be overcome?

6. What do you identify has the incentives and barriers to community engagement?

7. What was good about the community engagement process for your organisation?

8. What are some other benefits that the communities may derive which are not directly associated with the projects delivered, but which may promote their health and wellbeing?

9. What projects do you know of that have been put in place by the *Well London* programme in your community? How do you think these projects have addressed the issues which are important to the community?

10. How can the community be engaged in a way that makes them feel empowered and in control of the projects?

11. What do you think are some of the factors that prevent people from being fully engaged in community activities? What are the characteristics of the people who engage in the community?

Finally, are there any other comments you would like to make about the community engagement process?

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Evaluation of Community Engagement on the Design and Delivery of Health Promotion Interventions

Topic Guide for Interviews with Well London Partners

Introduction

Aims of the study and how information will be used

Role in organisation

<u>Questions</u>

1. How did the Well London community engagement process influence the design and delivery of health promotion projects in the communities for which you are lead partners and in communities in which your organisation delivered projects?

2. How has the community engagement process influenced your organisational thinking towards community engagement?

3. How has the community engagement process modified the structure and function of your organisation?

4. How do you propose to continue the process of community engagement in the communities for which you are lead partner?

5. What do you identify as challenges in the community engagement process? How were they / how can they be overcome?

6. What do you identify as the incentives and barriers to community engagement?

7. What was good about the community engagement process for your organisation?

8. How well do you think the Well London Alliance (partnership) worked together?

9. What are some other benefits that the communities may derive which are not directly associated with the projects delivered, but which may promote their health and wellbeing?

10. What are some of the lessons you have learnt which may help to make future community engagement more effective and easier for your organisation?

11. What type of community engagement process did your organisation use before the *Well London* community engagement process?

12. Finally, are there any other comments you would like to make about the community engagement process?

Written Document Examination Worksheet

1. Type of document

2. Unique features of document

3. Date(s) of document

4. Author/creator of document

5. Organisation responsible for document

6. Why was the document written?

7. For what audience was document written?

8. Document information

Appendix X – **Ethical Approval Letter and Health & Safety Approval**

UEL
University of
East London

Professor Adrian Renton
School of Health and Bioscience
Stratford

ETH/07/64/0

07 January 2008

Dear Professor Renton,

Application to the Research Ethics Committee: Evaluation of Community Engagement in Design and Delivery of Health Promotion Interventions.(O Sadare)

I advise that Members of the Research Ethics Committee have now approved the amendment to the above previously approved application.. The Research Ethics Committee should be informed of any significant changes in the programme that take place after approval has been given. Examples of such changes include any change to the location, number of participants, scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Debbie Dada
Administrative Officer for Research
d.dada@uel.ac.uk
02082232976

Research Ethics Committee: ETH/07/64/0

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:...Date: ....

Please Print Name:

Olamide Sadare

From: Gary Doyle [G.A.Doyle@uel.ac.uk]
Sent: 26 June 2007 12:18
To: Olamide Sadare
Cc: Krys Gunton
Subject: RE: Risk Assessment Form

Thanks, Approved.

Gary Doyle
Health and Safety Coordinator
School of Health and Bioscience
Ext 2404

-----Original Message-----
From: Olamide Sadare [mailto:O.Sadare@uel.ac.uk]
Sent: 21 May 2007 13:43
To: g.a.doyle@uel.ac.uk
Subject: Risk Assessment Form

<<Risk Assessment Form.doc>> <<FIELDWORK.doc>>
I am a PhD student about to submit my registration documents.Please find attached a completed
risk assessment form for my research project.

I have sent my ethics application to the School of Health and Bioscience.
Olamide Sadare
Institute of Health and Human Development
University of East London
University House
Romford Road
London E15 4LZ
020 8223 4045
Please visit the Institute's website at : www.uel.ac.uk/IHHD

03/07/2007

<div align="center">

INFORMATION SHEET
Well London Community Survey

</div>

You are being invited to take part in a research study. Before you decide whether to take part, we want to explain why the research is being done and what it will involve if you take part. Please take time to read the following information carefully. If something is not clear or if you would like more information, please ask the interviewer to explain. If you still do not understand after asking the interviewer, please call the study team on the number at the end of this sheet. If you would like to have this information sheet in another language, please either asks the interviewer to give you a translated version, or call the study team on the number provided below. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
This is a questionnaire-based survey, which is asking questions about diet, physical activity, general health and wellbeing of people living in several boroughs in London including the one you are living in. Only adults (16 years or older) are being invited to participate in this study. The survey is part of a large programme funded by the Big Lottery Fund which aims to improve the health and wellbeing of Londoners. The study also aims to find out your views and opinions concerning the community cafés.

What will you have to do if you take part?
If you want to take part, just collect a questionnaire and complete it. If you would like help completing the questionnaire, there will be someone at the community café who will be able to assist you. The interview consists of about 40 short questions and takes approximately 25 minutes to complete. Some questions will ask about age, whether you are married, your education, occupation and income. Others will ask about eating habits and general health.

Do I have to take part?
You are completely free to decide if you take part in the study. If you do decide to take part, you are free to change your mind and stop at any time without giving a reason. You can also "pass" any question that you do not wish to answer. If you change your mind about taking part at any time during the interview, you can stop and there will be no penalty or disadvantage to you or other members of their household in any way.

What are the possible advantages of taking part?
You will help us to better understand the needs of people living in London and to design programmes that will help Londoners to become healthier.

What are the possible disadvantages or risks of taking part?
There are no disadvantages or risks of taking part in the study.

What will happen to the information?
Information about you and your answers will be kept strictly confidential, and will be coded so that you cannot be identified. The information will be securely stored for ten years and will then be destroyed. The results of this study will be presented in the form of a report and may be further disseminated for scientific benefit and used in a PhD thesis. The results will be available to you on request.

Who should I contact for further information or if I have any problems/concerns?

A member of the study team can be contacted at 02082234045.

Appendix XII – **Consent Form for Questionnaire Surveys**

CONSENT FORM

Well London Community Survey

I confirm that I have read the information sheet for the above study and I have been given a copy to keep.

I understand what the study is about and I have had the opportunity to talk and ask questions about the study.

The procedures involved have been explained to me. I know what my part will be in the study and how the study may affect me.

I understand that my involvement in this study and particular data from this research will remain strictly confidential. Only researchers involved in the study will have access to the data.

It has been explained to me what will happen to the data once the study has been completed.

I understand that I have the right to stop taking part in the study at any time and I am not obliged to give any reason.
.
I know that if I do withdraw, it will not disadvantage me.

I know who to contact if I have any questions/concerns about my participation and I have their contact details.

I fully and freely consent to participate in the study.

_____

Participant's Name (BLOCK CAPITALS):

Participant's Signature:

Date:

Interviewer's Signature:

Interviewer's Name (BLOCK CAPITALS):

Date:

Appendix XIII – **Information Sheet for Qualitative Interview**

Evaluation of Community Engagement on the Design and Delivery of Health Promotion Interventions

Information Sheet

Aims of the study and how the information will be used

You are being invited to take part in a research study. Before you decide whether to take part we want to explain why the research is being done and what it will involve if you take part. Please take time to read the following information carefully. If anything is not clear or if you would like more information please ask the interviewer to explain. If you still do not understand after asking the interviewer please call the study team on the number at the end of this sheet. If you would like to have this information sheet in another language, please either asks the interviewer to give you a translated version, or call the study team on the number provided below. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to find out your views and opinions concerning the Well London community cafés in particular and about your views of community engagement in general. It aims to gather information which can help to improve community engagement by contributing individuals' views of the process.

What will you have to do if you take part?

If you want to take part, please give your consent by reading and signing the consent form. You will then be asked some questions about the community engagement process. The interview consists of about 10 questions and should take about 45 minutes to an hour. Please answer them as best as you can, giving details and examples where necessary. The interview will be recorded with an audio-recording device. This is to ensure that the conversation is properly and accurately documented.

Do I have to take part?

You are completely free to decide if you take part in the study. If you do decide to take part, you are free to change your mind and stop at any time without giving a reason. You can also "pass" any question that you do not wish to answer. If you change your mind about taking part at any time during the interview, you can stop and there will be no penalty or disadvantage to you or other members of their household in any way.

What are the possible advantages of taking part?

You will help us to better understand the impact and effects of engaging the community in the design and delivery of health promotion programmes and projects in the community. This will help to inform community engagement workers on how to effectively engage the community to achieve the best possible results.

What are the possible disadvantages or risks of taking part?

There are no disadvantages or risks of taking part in the study.

What will happen to the information?

The audio recording will be transcribed and information about you and your answers will be kept strictly confidential, and will be coded so that you cannot be identified. The information will be securely stored for ten years and will then be destroyed. The results of this study will be presented in the form of a report and may be further disseminated for scientific benefit and used in a PhD thesis. The results will be available to you on request.

Who should I contact for further information or if I have any problems/concerns?

If you have any concerns or would like further information about the study, please contact Professor Adrian Renton on 0208 223 4539 or Dr Elena Schmidt on 0208 223 4081.

Alternatively you can write:

Institute for Health and Human Development

School of Health and Bioscience

University of East London (UeL)

Romford Road

London E15 4LZ

Evaluation of Community Engagement on the Design and Delivery of Health Promotion Interventions

Consent form

I confirm that I have read the information sheet for the above study and I have been given a copy to keep.

I understand what the study is about and I have had the opportunity to talk and ask questions about the study.

The procedures involved have been explained to me. I know what my part will be in the study and how the study may affect me.

I understand that my involvement in this study and particular data from this research will remain strictly confidential. Only researchers involved in the study will have access to the data.

It has been explained to me what will happen to the data once the study has been completed.

I understand that I have the right to stop taking part in the study at any time and I am not obliged to give any reason.

I know that if I do withdraw, it will not disadvantage me.

I know who to contact if I have any questions/concerns about my participation and I have their contact details.

I fully and freely consent to participate in the study.

Participant's Signature:

Participant's Name (BLOCK CAPITALS):

Date:

Interviewer's Signature:

Interviewer's Name:

Date:

Appendix XV – **Questionnaire Survey Data**

. * **Section 1: Tabulations of Categorical Variables**

-> source = Lami data

-> age group

```
  RECODE of |
        age |      Freq.      Percent        Cum.
------------+-----------------------------------
        <16 |          4         3.33         3.33
      16-24 |         12        10.00        13.33
      25-34 |         20        16.67        30.00
      35-44 |         37        30.83        60.83
      45-54 |         13        10.83        71.67
      55-64 |         18        15.00        86.67
        65+ |         16        13.33       100.00
------------+-----------------------------------
      Total |        120       100.00
```

-> gender

```
     Gender |      Freq.      Percent        Cum.
------------+-----------------------------------
       male |         32        24.24        24.24
     female |        100        75.76       100.00
------------+-----------------------------------
      Total |        132       100.00
```

-> employment status

```
               Employment Status |      Freq.      Percent        Cum
--------------------------------+-----------------------------------
                       Employed |         55        43.65        43.65
                   FT Education |         14        11.11        54.76
                     Unemployed |         14        11.11        65.87
                        Retired |         20        15.87        81.75
                     Home-maker |          9         7.14        88.89
      Not work illness/disability |         11         8.73        97.62
                          Other |          3         2.38       100.00
--------------------------------+-----------------------------------
                          Total |        126       100.00
```

-> educational attainment

```
  Education |      Freq.      Percent        Cum.
------------+-----------------------------------
    Primary |         13        10.40        10.40
  Secondary |         50        40.00        50.40
    A level |          9         7.20        57.60
     Higher |         49        39.20        96.80
      Other |          4         3.20       100.00
------------+-----------------------------------
      Total |        125       100.00
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
-> marital status

   Marital Status |      Freq.     Percent        Cum.
------------------+-----------------------------------
    Never Married |        40       30.77       30.77
  Married/cohabit |        47       36.15       66.92
        Separated |        12        9.23       76.15
         Divorced |        19       14.62       90.77
          Widowed |        12        9.23      100.00
------------------+-----------------------------------
            Total |       130      100.00


-> religion

         Religion |      Freq.     Percent        Cum.
------------------+-----------------------------------
     Christianity |        58       47.93       47.93
            Islam |        23       19.01       66.94
            Other |         8        6.61       73.55
             None |        32       26.45      100.00
------------------+-----------------------------------
            Total |       121      100.00


-> ethnicity

   Ethnicity Group |      Freq.     Percent        Cum.
------------------+-----------------------------------
            White |        71       54.20       54.20
            Black |        36       27.48       81.68
            Asian |        11        8.40       90.08
            Mixed |         7        5.34       95.42
            Other |         6        4.58      100.00
------------------+-----------------------------------
            Total |       131      100.00


-> country of birth

 Country of |
      Birth |      Freq.     Percent        Cum.
------------+-----------------------------------
         UK |        70       53.85       53.85
     Non-UK |        60       46.15      100.00
------------+-----------------------------------
      Total |       130      100.00


-> reported level of  happiness

                      Happiness |      Freq.     Percent        Cum.
-------------------------------+-----------------------------------
Not very happy/not at all happy |        24       21.05       21.05
                    Quite happy |        65       57.02       78.07
                     Very happy |        25       21.93      100.00
-------------------------------+-----------------------------------
                          Total |       114      100.00
```

-> satisfaction with area

Satisfaction with area	Freq.	Percent	Cum.
Very dissatisfied	22	18.18	18.18
Neither satisfied nor dissatisfied	32	26.45	44.63
Very satisfied & satisfied	58	47.93	92.56
No opinion/no answer	9	7.44	100.00
Total	121	100.00	

-> feeling of safety when dark

Feeling of safety when dark	Freq.	Percent	Cum.
Never out alone when dark	13	10.40	10.40
Very unsafe	31	24.80	35.20
A bit unsafe	45	36.00	71.20
Fairly safe	28	22.40	93.60
Very safe	8	6.40	100.00
Total	125	100.00	

-> length of stay in neighbourhood

RECODE of Yrs_in_area	Freq.	Percent	Cum.
0-5	19	29.23	29.23
6-10	12	18.46	47.69
11-20	13	20.00	67.69
21-30	12	18.46	86.15
31+	9	13.85	100.00
Total	65	100.00	

-> source = 1. Well London Survey 2008

-> age group

age	Freq.	Percent	Cum.
16-24	776	20.96	20.96
25-34	1,018	27.50	48.46
35-44	807	21.80	70.26
45-54	454	12.26	82.52
55-64	288	7.78	90.30
65+	359	9.70	100.00
Total	3,702	100.00	

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
-> gender

    Gender |      Freq.      Percent         Cum.
------------+-----------------------------------
      male |      1,815       44.98        44.98
    female |      2,220       55.02       100.00
------------+-----------------------------------
     Total |      4,035      100.00


-> employment status

            Employment Status |      Freq.      Percent         Cum.
------------------------------+------------------------------------
-
                     Employed |      1,676       43.76        43.76
                 FT Education |        490       12.79        56.55
                   Unemployed |        763       19.92        76.48
                      Retired |        398       10.39        86.87
                   Home-maker |        210        5.48        92.35
Not working illness/disability |       218        5.69        98.04
                        Other |         75        1.96       100.00
------------------------------+------------------------------------
-                       Total |      3,830      100.00


-> educational attainment

    Education |      Freq.      Percent         Cum.
------------+-----------------------------------
     Primary |        381       10.43        10.43
   Secondary |      1,223       33.48        43.91
     A level |        969       26.53        70.44
      Higher |      1,044       28.58        99.01
       Other |         36        0.99       100.00
------------+-----------------------------------
       Total |      3,653      100.00


-> marital status

    Marital Status |      Freq.      Percent         Cum.
---------------+-----------------------------------
 Never Married |      1,800       45.02        45.02
Married/cohabit |     1,666       41.67        86.69
     Separated |        131        3.28        89.97
      Divorced |        232        5.80        95.77
       Widowed |        169        4.23       100.00
---------------+-----------------------------------
         Total |      3,998      100.00
-> religion

    Religion |      Freq.      Percent         Cum.
------------+-----------------------------------
 Christianity |      2,016       51.10        51.10
       Islam |        703       17.82        68.92
       Other |        343        8.69        77.62
        None |        883       22.38       100.00
------------+-----------------------------------
       Total |      3,945      100.00
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
-> ethnicity

  Ethnicity Group |      Freq.       Percent         Cum.
------------------+-----------------------------------
           White |      1,787        44.63         44.63
           Black |      1,124        28.07         72.70
           Asian |        601        15.01         87.71
           Mixed |        191         4.77         92.48
           Other |        301         7.52        100.00
------------------+-----------------------------------
           Total |      4,004       100.00


-> country of birth

 Country of |
      Birth |      Freq.       Percent         Cum.
------------+-----------------------------------
         UK |      2,006        50.95         50.95
     Non-UK |      1,931        49.05        100.00
------------+-----------------------------------
      Total |      3,937       100.00


-> reported level of happiness

                       Happiness |      Freq.       Percent         Cum.
--------------------------------+-----------------------------------
Not very happy/not at all happy |        569        14.32         14.32
                    Quite happy |      2,498        62.87         77.20
                     Very happy |        906        22.80        100.00
--------------------------------+-----------------------------------
                          Total |      3,973       100.00


-> satisfaction with area

                Satisfaction with area |      Freq.       Percent         Cum.
--------------------------------------+-----------------------------------
                     Very dissatisfied |        617        15.22         15.22
Neither satisfied nor dissatisfied |        824        20.32         35.54
            Very satisfied & satisfied |      2,557        63.06         98.59
                  No opinion/no answer |         57         1.41        100.00
--------------------------------------+-----------------------------------
                                 Total |      4,055       100.00


-> feeling of safety when dark

  Feeling of safety when |
                    dark |      Freq.       Percent         Cum.
------------------------+-----------------------------------
Never out alone when dark |        536        13.21         13.21
               Very unsafe |        627        15.46         28.67
               A bit unsafe |      1,002        24.70         53.38
               Fairly safe |      1,586        39.10         92.48
                 Very safe |        305         7.52        100.00
------------------------+-----------------------------------
                   Total |      4,056       100.00
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
-> length of stay in neighbourhood

  RECODE of |
Yrs_in_area |      Freq.      Percent        Cum.
------------+-----------------------------------
        0-5 |      1,862       48.65       48.65
       6-10 |        866       22.63       71.28
      11-20 |        713       18.63       89.91
      21-30 |        247        6.45       96.37
        31+ |        139        3.63      100.00
------------+-----------------------------------
      Total |      3,827      100.00
```

. * **Section 2: Summary of continuous variables**

-> **source = Lami data**

```
          Number of years in the UK for those born outside the UK
          ----------------------------------------------------------------
      Percentiles        Smallest
 1%            0               0
 5%            1               1
10%            5               1          Obs                       58
25%           10               3          Sum of Wgt.               58

50%           17                          Mean                22.48276
                          Largest         Std. Dev.           15.95085
75%           40              49
90%           47              49          Variance            254.4295
95%           49              51          Skewness            .4679138
99%           52              52          Kurtosis            1.819369
```

```
                    Number of years in neighbourhood
          ----------------------------------------------------------------
      Percentiles        Smallest
 1%            0               0
 5%            1               1
10%            2               1          Obs                       65
25%            5               1          Sum of Wgt.               65

50%           13                          Mean                16.72308
                          Largest         Std. Dev.           14.57364
75%           25              40
90%           36              51          Variance            212.3909
95%           40              56          Skewness            1.286118
99%           70              70          Kurtosis             4.81388
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
-> source = 1. Well London Survey 2008
----------------------------------------------------------------------

 Number of years in the UK for those born outside the UK
-----------------------------------------------------------------
      Percentiles      Smallest
 1%          .25       .0833333
 5%            1       .0833333
10%            3       .0833333      Obs                  2182
25%            6       .0833333      Sum of Wgt.          2182

50%           13                     Mean             17.27257
                       Largest       Std. Dev.        15.08357
75%     22.41667            86
90%           40            86       Variance         227.5142
95%           48            87       Skewness         1.480458
99%           69            97       Kurtosis          5.34164




                 Number of years in neighbourhood
-----------------------------------------------------------------
      Percentiles      Smallest
 1%     .0833333       .0833333
 5%          .25       .0833333
10%     .6666667       .0833333      Obs                  3827
25%            2       .0833333      Sum of Wgt.          3827

50%            6                     Mean             8.699569
                       Largest       Std. Dev.        9.214387
75%           12            50
90%           21            60       Variance         84.90493
95%           30            61       Skewness         1.917782
99%           41            91       Kurtosis         7.869688
```

. *** Section 3: Tests**
. /*
> difference in the proportion of the variables of your interest between
Lami's data and WL data.
>
> The Chi-square value is a single number that adds up all the
differences between datasets. If no difference, the Chi2's value is 0.
The larger the Chi2 value, the greater the probability that there really
is a significant difference.
> The null hypothesis is that there is a difference.
> If the Chi2 value is greater than or equal to the critical value, then
we cannot reject the null hypothesis.
> The value in bracket is degree of freedom
. * simple Chi2 test for categorical variables

```
           |          source
    Gender | Lami data     Well L |     Total
-----------+----------------------+----------
      male |        32      1,815 |     1,847
    female |       100      2,220 |     2,320
-----------+----------------------+----------
     Total |       132      4,035 |     4,167
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
        Pearson chi2(1) =  22.2772   Pr = 0.000


                      |        source
     Employment Status | Lami data    Well L |      Total
    ----------------------+----------------------+----------
              Employed |       55     1,676 |      1,731
          FT Education |       14       490 |        504
            Unemployed |       14       763 |        777
               Retired |       20       398 |        418
            Home-maker |        9       210 |        219
    Not working due to il |     11       218 |        229
                 Other |        3        75 |         78
    ----------------------+----------------------+----------
                 Total |      126     3,830 |      3,956

        Pearson chi2(6) =  11.2243   Pr = 0.082


                 |        source
        Education | Lami data    Well L |      Total
    -----------------+----------------------+----------
          Primary |       13       381 |        394
        Secondary |       50     1,223 |      1,273
          A level |        9       969 |        978
           Higher |       49     1,044 |      1,093
            Other |        4        36 |         40
    -----------------+----------------------+----------
            Total |      125     3,653 |      3,778

        Pearson chi2(4) =  29.2746   Pr = 0.000


                 |        source
   Marital Status | Lami data    Well L |      Total
    -----------------+----------------------+----------
    Never Married |       40     1,800 |      1,840
   Married/cohabit |       47     1,666 |      1,713
        Separated |       12       131 |        143
         Divorced |       19       232 |        251
          Widowed |       12       169 |        181
    -----------------+----------------------+----------
            Total |      130     3,998 |      4,128

        Pearson chi2(4) =  42.8171   Pr = 0.000


                 |        source
         Religion | Lami data    Well L |      Total
    -----------------+----------------------+----------
     Christianity |       58     2,016 |      2,074
            Islam |       23       703 |        726
            Other |        8       343 |        351
             None |       32       883 |        915
    -----------------+----------------------+----------
            Total |      121     3,945 |      4,066

        Pearson chi2(3) =   1.7754   Pr = 0.620
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
                  |          source
  Ethnicity Group | Lami data     Well L |     Total
------------------+----------------------+----------
            White |        71      1,787 |     1,858
            Black |        36      1,124 |     1,160
            Asian |        11        601 |       612
            Mixed |         7        191 |       198
            Other |         6        301 |       307
------------------+----------------------+----------
            Total |       131      4,004 |     4,135

          Pearson chi2(4) =   7.9096   Pr = 0.095


Country of |          source
     Birth | Lami data     Well L |     Total
-----------+----------------------+----------
        UK |        70      2,006 |     2,076
    Non-UK |        60      1,931 |     1,991
-----------+----------------------+----------
     Total |       130      3,937 |     4,067

          Pearson chi2(1) =   0.4217   Pr = 0.516

.
.
```

* chi2 test for trend
. /*
> It performs an approximate chi-squared test of homogeneity of odds and
> a test for linear trend of the log odds against the numerical code used
> for the categories of variables of interest. Both tests are based on
the score statistic and its variance.
>
> The table is a K by 2, the test for equality of the odds ratio is a
chi2 with (K-1) x (2-1) degrees of freedom. If the test for homogeneity
of the odds is significant at the 0.001 level, there is indication that
there is a difference between Lami's and WL. The score test for trend
provides indication that there is a number-response relationship.

Case: Well London data
Control: Lami's data

```
----------------------------------------------------------------------
agegrp  |      cases     controls       odds     [95% Conf. Interval]
--------+-------------------------------------------------------------
- <16 |          0            4    0.00000          .           .
  16-24 |        776           12   64.66667     36.56513 114.36518
  25-34 |       1018           20   50.90000     32.69812  79.23423
  35-44 |        807           37   21.81081     15.68784  30.32358
  45-54 |        454           13   34.92308     20.12220  60.61073
  55-64 |        288           18   16.00000      9.93837  25.75875
    65+ |        359           16   22.43750     13.59827  37.02246
----------------------------------------------------------------------
Test of homogeneity (equal odds): chi2(6)   =    148.78
                                  Pr>chi2    =    0.0000

Score test for trend of odds:     chi2(1)    =     10.46
                                  Pr>chi2    =    0.0012
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
-----------------------------------------------------------------------------
-
 happy   |       cases     controls        odds       [95% Conf. Interval]
------------+----------------------------------------------------------Not
ver~y|          569            24    23.70833        15.75882  35.66796
Quite h~y|     2498            65    38.43077         30.04248  49.16120
Very ha~y|      906            25    36.24000         24.35651  53.92142
-----------------------------------------------------------------------
Test of homogeneity (equal odds): chi2(2)   =      4.10
                                  Pr>chi2   =    0.1286

Score test for trend of odds:     chi2(1)   =      1.75
                                  Pr>chi2   =    0.1858
```

```
satisf   |       cases     controls        odds       [95% Conf. Interval]
------------+----------------------------------------------------------Very
di~d |      617            22    28.04545        18.33068  42.90880
Neither~i |     824            32    25.75000         18.08884  36.65589
 Very sa~d |    2557            58    44.08621         33.98396  57.19150
-----------------------------------------------------------------------
Test of homogeneity (equal odds): chi2(2)   =      7.09
                                  Pr>chi2   =    0.0288

Score test for trend of odds:     chi2(1)   =      5.21
                                  Pr>chi2   =    0.0224
```

```
-----------------------------------------------------------------------
 safe    |       cases     controls        odds       [95% Conf. Interval]
------------+----------------------------------------------------------
Never o~k |      536            13    41.23077         23.78454  71.47399
  Very un~e |     627            31    20.22581         14.10236  29.00814
  A bit u~e |    1002            45    22.26667         16.51762  30.01669
  Fairly ~e |    1586            28    56.64286         38.98248  82.30399
  Very safe |     305             8    38.12500         18.89485  76.92656
-----------------------------------------------------------------------
Test of homogeneity (equal odds): chi2(4)   =     22.60
                                  Pr>chi2   =    0.0002

Score test for trend of odds:     chi2(1)   =      4.59
                                  Pr>chi2   =    0.0321
```

```
-----------------------------------------------------------------------
year_ne~r  |     cases     controls        odds       [95% Conf. Interval]
------------+----------------------------------------------------------
-
       0-5 |     1862            19    98.00000         62.36677 153.99226
      6-10 |      866            12    72.16667         40.82435 127.57159
     11-20 |      713            13    54.84615         31.69005  94.92257
     21-30 |      247            12    20.58333         11.53179  36.73961
       31+ |      139             9    15.44444          7.87040  30.30733
-----------------------------------------------------------------------
Test of homogeneity (equal odds): chi2(4)   =     36.92
                                  Pr>chi2   =    0.0000
```

Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions

```
Score test for trend of odds:      chi2(1)   =     28.51
                                    Pr>chi2   =    0.0000


. * MW U test for continuous variables

Years in UK
Two-sample Wilcoxon rank-sum (Mann-Whitney) test

        source |       obs     rank sum     expected
-------------+-------------------------------
   Lami data |       58     77778.5        64989
1. Well Lond |     2182   2432141.5      2444931
-------------+-------------------------------
    combined |     2240    2509920      2509920

unadjusted variance      23634333
adjustment for ties     -20241.741
                         ----------
adjusted variance        23614091

Ho: yr2uk(source==Lami data) = yr2uk(source==1. Well London Survey 2008)
          z =    2.632
   Prob > |z| =   0.0085


Years in neighbourhood

Two-sample Wilcoxon rank-sum (Mann-Whitney) test

        source |       obs     rank sum     expected
-------------+-------------------------------
   Lami data |       65      172095      126522.5
1. Well Lond |     3827     7403683     7449255.5
-------------+-------------------------------
    combined |     3892     7575778      7575778

unadjusted variance      80700268
adjustment for ties     -147482.35
                         ----------
adjusted variance        80552786

Ho: plnowy(source==Lami data) = plnowy(source==1. Well London Survey
2008)
          z =    5.078
   Prob > |z| =   0.0000

. * T-test for continuous variables

Two-sample t test with unequal variances
-----------------------------------------------------------------------Group
|     Obs      Mean     Std. Err.    Std. Dev.    [95% Conf.interval]
---------+-------------------------------------------------------------
Lami d   |      58    22.48276     2.094449     15.95085     18.2887   26.67682
 Well    |    2182    17.27257     .3229065     15.08357     16.63933 17.90581
------+----------------------------------------------------------------
combined |    2240    17.40748     .3195859     15.12557     16.78076 18.03419
---------+-------------------------------------------------------------
```

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```
   diff |           5.210188    2.119194            .9707898  9.449585
---------------------------------------------------------------------
diff = mean(Lami dat) - mean(1. Well)                   t =   2.4586
Ho: diff = 0            Satterthwaite's degrees of freedom =  59.741

Ha: diff < 0                Ha: diff != 0                 Ha: diff > 0
Pr(T < t) = 0.9916     Pr(|T| > |t|) = 0.0169      Pr(T > t) = 0.0084


Two-sample t test with unequal variances
---------------------------------------------------------------------
 Group |   Obs       Mean    Std. Err.    Std. Dev.  [95% Conf. Interval]
-------+-------------------------------------------------------------
Lami dat |  65    16.72308   1.807637    14.57364    13.11191   20.33425
    Well |3827     8.699569   .1489489    9.214387    8.407542   8.991596
-------+-------------------------------------------------------------
combined |3892     8.833569   .1503999    9.382829    8.538699   9.128439
-------+-------------------------------------------------------------
 diff |           8.023508   1.813763               4.401037   11.64598
---------------------------------------------------------------------
diff = mean(Lami dat) - mean(1. Well)                   t =   4.4237
Ho: diff = 0            Satterthwaite's degrees of freedom =  64.872

   Ha: diff < 0               Ha: diff != 0                 Ha: diff > 0
 Pr(T < t) = 1.0000     Pr(|T| > |t|) = 0.0000      Pr(T > t) = 0.0000
```

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