

Portfolio of Doctorate in Health Psychology

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PREFACE

Throughout the Stage 2 training I held a number of positions and roles to demonstrate the competencies required to achieve the Doctorate in Health Psychology. This has involved working across NHS and University organisations holding workplace contracts within a Maternal Fetal research unit, Epidemiology and Public Health department, Health Improvement service and Community Children's Nursing service. This has provided me with a wide variety of experiences, which are reflected within the chapters of this portfolio in order to demonstrate the expertise and skills required to achieve Health Psychologist status.

The main areas of my work have been across the fields of child and maternal health, health promotion skills of health professionals and culturally appropriate lifestyle interventions. Key topic areas include: weight management during pregnancy, parental conceptions of child health and weight, use of Motivational Interviewing skills by health professionals and understanding health beliefs held by UK South Asians. I have worked with various different populations including patients, healthcare professionals, early year's professionals and students.

Research

The research study idea developed whilst working on the evaluation of the National Child Measurement Programme. Through interviewing and exploring parent views on child weight, unique issues surfaced during interviews with South Asian families. Through my work in the Epidemiology and Public Health department I was aware South Asians manifest obesity-related diseases more frequently and earlier than other groups. A potential worsening of obesity related risk in South Asian children carries implications for persisting disparities in chronic disease across generations. Thus making it advantageous to target this specific group for obesity prevention. Psychosocial factors are particularly important in childhood obesity and there is a lack of research looking to understand the determinants of dietary and physical activity

behaviour and factors that might influence behaviour modification in South Asians. Therefore my study aimed to identify beliefs and perceptions about healthy lifestyles in UK South Asian families in order to develop a theory which can be used to define specific objectives, and alter the hypothesised mediators in a way that leads to effective behaviour change for this population, in order to improve health outcomes. To explore the topic, given the lack of current research in this specific group, an interpretivist classic version of grounded theory was utilised.

The findings that emerged shaped an explanatory model with which to describe the key concepts in how mothers are engaged in a balancing act to resolve the pressures and conflicts around engaging in health behaviours and how the variables interact to influence their negotiation of a healthy lifestyle. The study indicates high importance is attached to group norms and social values influencing motivation and confidence to undertake particular health behaviours. Also, providing an insight into misperceptions commonly held about health risks. Given the elevated risk of lifestyle related disease in South Asian communities this study contributes to an improved understanding of the factors underlying young South Asian family's health behaviours and the theory can be used to inform the selection and sequence of intervention strategies.

Reflecting on my research journey, I can see different kinds of learnings including developing my understanding and appreciation of the value of theory in public health; increasing my understanding of grounded theory and my practical skills in qualitative research and gaining a real appreciation of the value of the grounded theory approach for its ability to produce useful findings and for what it teaches the researcher about analysis.

Consultancy

During my training for the consultancy competence I worked for a Epidemiology and Public Health department. Initially this was to interview participants exploring their attitudes and beliefs around childhood obesity and towards their child's overweight status. This was a useful insight into how health psychologists can work on short-

term contracts and use their expertise to work as a consultant on various consultancy projects. Having conducted a number of consultancies during training, enclosed is a case study of a consultancy project which aimed to explore childhood obesity management in primary care of which I collected and analysed the data using qualitative research methods.

Being one of few staff members in the research team experienced in qualitative research I was able to contribute these skills to the projects along with my knowledge of behaviour change techniques and use of health promotion in practice. Working within a multi-skilled research team provided an opportunity to benefit and learn from the skills of other researchers as we worked together on analysing data, literature searches for reviews, developing projects and completing grant applications. The initial consultancy led to various other projects over two years which enabled me to develop knowledge and expertise in other topic areas of how Health Psychology can be applied to research and intervention development.

Teaching and Training

Throughout my training I taught healthcare professionals, early year's professionals and students to whom I delivered many MSc and BSc teaching sessions. Teaching and training provided me with an opportunity to impart health psychology knowledge and application across a wide number of settings. I worked across three universities, various NHS trusts and other providers to deliver training.

Two teaching sessions have been chosen to present within this portfolio which offer valuable representations of my development as a teacher. The sessions are both on MSc Health Psychology modules where I developed the teaching materials, a teaching plan and evaluation process for each sessions. I enjoyed the opportunity to share some of my learning as a trainee Health Psychologist with students.

Attending teaching and training workshops and receiving feedback from participants on the, Stage 2 and work colleagues has been beneficial in terms of improving my training and teaching style and confidence in being able to deliver training to a wide variety of audiences.

Interventions in Health Psychology

Within my role as Health Development advisor I aimed to promote and encourage active lifestyles amongst young families to help prevent and address the health challenges faced. I identified the local Walking Together programme as an opportunity to deliver an intervention to target parents to stay active with their children over summer holiday period by engaging them with the walking programme. The intervention titled, 'Take a parent for a walk this summer holiday' was designed using concepts from the Health Belief Model. The outcome of the intervention was a substantial increase in the number of children attending the walks with minimal cost implications. Thus providing an excellent example of putting Health Psychology principles into practice.

In terms of the value of these findings, the intervention could be delivered in any area where health walk programmes run. Therefore I presented the findings in a report disseminated to the commissioners to assist future funding opportunities. Also, to the national health walk programme to be shared with other health walk providers around the country and the volunteer walk leaders who delivered the programme to show them the outcomes of their hard work.

Systematic Review

As a component of the Health Psychology doctorate and in order to support work in my consultancy role with Dr Sanjay Kinra, I completed a review of the available qualitative literature for health beliefs and perceptions specific to UK South Asian adults in relation to lifestyle related disease, to guide future interventions in this group. There remains little evidence of successful interventions to reduce lifestyle

related disease risk among South Asian groups and theories of health behaviour only specify a limited subset of cognitive determinants that are assumed to be most proximal to the general population's behaviour.

The review presented that cultural and social norms strongly influence physical activity incidence and motivation as well as the ability to engage in healthy eating practices. The findings highlight that acknowledgement of their approach to lifestyle behaviours may assist acceptability of interventions and delivery of lifestyle advice by health professionals. The study was accepted for publication within the peer-reviewed Journal of Obesity (Lucas, Murray & Kinra, 2013). Disseminating findings within peer-reviewed journals is an important skill and to be able to share research conducted.

Theoretical and practical experience

This portfolio demonstrates the skills and knowledge of a trainee Health Psychologist and how all the various competencies have been achieved. The portfolio consists of case studies on professional skills, consultancy, teaching and training and intervention to elicit behaviour change. Undertaking the doctoral programme has produced many opportunities to put skills into practice such as designing research interview agendas, critically evaluating previous research, writing up the findings (systematic review) and completing my own piece of research.

Over the last three and a half years it has proven to be a practical and hands-on learning experience of growing in confidence and developing my skills as a Health Psychologist with particular emphasis on my skills as a researcher, teacher and consultant and my role as a health professional in the NHS. Managing multiple roles

was challenging but enabled me to learn how to balance work and study and develop my skills in a variety of areas.

Approaching the end of Stage 2 poses many opportunities, exciting challenges and scope as I start a new secondment role within a Local Authority Public Health team where I hope to practice as a Health Psychologist. I have also gained training places on a NHS leadership course and an innovation in community healthcare course which will be another challenge I look forward to beginning. In addition, I also plan to seek out new part time teaching opportunities and further explore how to apply Health Psychology in the NHS.

SECTION A RESEARCH

A grounded theory of the balancing act South Asian mothers engage in to negotiate a healthy family lifestyle.

Abstract

Introduction

Overall the evidence is consistent and robust that UK South Asian communities are at elevated risk of lifestyle related disease. A potential worsening of obesity related risk in South Asian children carries implications for persisting disparities in chronic disease across generations making it advantageous to target this specific group for obesity prevention. Psychosocial factors are particularly important in obesity and key to understanding the determinants of dietary and physical activity behaviour, and factors that might influence behaviour modification in South Asians. The study aims to identify beliefs and perceptions that contribute to health risk and health protective behaviours in young UK South Asian families and to develop a theory which can be used to define specific objectives that lead to effective behaviour change to improve health outcomes for this population.

Design

Grounded theory methodology was applied to investigate how factors influence South Asian mother's decisions to engage in health behaviours for themselves and their children taking into account specific beliefs and practices influencing health behaviours. Semi-structured interviews were carried out with seven female participants who were mothers to young children aged 5-12 years of age.

Results

The grounded theory is underpinned by three categories that emerged out of analysis of the data; cultural identity, health beliefs and barriers. These categories and their properties, tell the story of the influences and pressures on South Asian mothers as they attempt to negotiate a healthy family lifestyle. The data emerged to form a grounded theory of the balancing act South Asian mothers engage in to negotiate a healthy family lifestyle.

Conclusions

This study contributes to an improved understanding of the unique factors influencing young South Asian family's health behaviours and recognition of the need to help them to find a healthier lifestyle balance. In addition, it has revealed how these factors relate to the initiation and maintenance of a healthy lifestyle and will be of use to health professionals and service providers when designing interventions to address and prevent health inequalities among this group. Emphasising the need to involve both the family and their community in interventions, in order for them to be effective. Limitations of these findings and their implications for future research and practice are considered.

Chapter 1. Introduction

This introductory chapter explains how the aims and scope of this study developed, and outlines the initial positions and values underpinning it. It sets out the background and context of this study and how the framework emerged. The common assumptions that underpin this research are set out along with a description of the motivation and drive for this research, detailing my experience in the area and with this population and how this shaped my commitment to wanting to contribute to engagement with healthy lifestyles by the UK South Asian¹ population.

1.1 Shaping a research project

Living and working in the multi-ethnic urban areas in the UK heightened my awareness to the high rates of lifestyle related disease in minority ethnic groups. In particular I was struck by the high rates of type 2 diabetes in the South Asian population and the impact of lifestyle related disease² on quality of life in this group. South Asians have been found to be susceptible to obesity (particularly central obesity), Type 2 diabetes, and Cardiovascular disease (McKeigue, Shah, Marmot, 1991, Jafar, Levey, White, Gul, Jessani, Khan, et al. 2004). The age-adjusted prevalence of diabetes has been estimated to be around 20% among British South Asians, nearly fivefold higher than the indigenous population in Britain (Gholap, Davies, Patel, Sattar, Khunti, 2011) significantly greater than in many other ethnic groups with disease onset at younger ages and at lower levels of risk (Health and Social Care Information Centre, 2004). This increased susceptibility to diabetes is in part determined by genetic factors, as for South Asians the risk of diabetes and cardiovascular disease has been found to occur at lower levels of Body Mass Index (BMI) compared to a European population (Joshi, Islam & Pais et al., 2007). Additionally, UK South Asian children and adolescents have a markedly increased risk of type 2 diabetes compared to UK White children (Ehtisham, Hattersley, Dunger & Barrett, 2004). Genetic, epigenetic, and lifestyle factors, as well as gene–environment interactions, have been proposed to explain the high susceptibility to these diseases (Abeywardena, 2003, Gholap, Davies, Patel, Sattar, Khunti, 2011,

¹*South Asian*: people living in the United Kingdom (UK) with ancestral origins from Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka.

²*Lifestyle-related disease*: diseases that have in common a behavioural influence in their development.

Misra, Khurana, 2011). Although genetic factors are important, the increased incidence of type 2 diabetes and cardiovascular disease in this group is strongly associated with increasing obesity (Duncan, Woodfield, Al-Nakeeb & Nevill, 2008). Previous statistics were interpreted as showing that South Asians were no more obese than the White UK population. However analyses of national (Connelly, 2011) and regional UK data (Cronberg, Wild, Fitzpatrick & Jacobsen, 2010) showed that after adjusting for socioeconomic status South Asian children were more likely to be obese than white children. Also, a few studies have compared Body Mass Index (BMI) and waist circumference between South Asians settled in Europe and their counterparts with similar cultural and genetic background in the country of origin: India (Patel, Vyas, Cruickshank, Prabhakaran, Hughes, Reddy, et al., 2006), Pakistan (Zahid, Meyer, Kumar, Claussen, Hussain, 2011), and Sri Lanka (Tennakoon, Kumar, Nugegoda, Meyer, 2010). These have consistently found higher BMI (2.1–5.8 BMI point difference) in the European Asians, compared to counterparts in their country of origin. Waist circumference was also found to be higher in the European Asians in most of these studies.

The adoption of norms, values and behaviour prevalent in the receiving society is described as acculturation and theories of acculturation have been positioned to explain changes in health behaviour among migrants that have longer term negative consequences for health outcomes. These outcomes can be improved through lifestyle changes to reduce risk factors such as a sedentary lifestyle, diet, smoking, stress and depression. Evidence includes the impact of higher levels of smoking, especially in pregnancy, lower levels of breastfeeding and diets with high fat content on rates of diabetes, cardio-vascular disease and cancer (Hawkins, Lamb, Cole & Law, 2008). This may be because during the process of acculturation, where cultural features are exchanged, and the original cultural patterns of either or both groups may be altered; however, the groups remain distinct (Kottak, 2004). A recent study (Falconer et al., 2014) found children from Asian ethnic groups are more likely to have obesogenic lifestyles than their white peers. Similarly, I found whilst working on the evaluation of the National Child Measurement Programme (NCMP) and interviewing parents of overweight children issues surfaced with South Asian families I interviewed that were not raised during interviews with other ethnic minority or white British groups. Findings from the Family Food Survey (2005–2007), show the

average consumption of fruit and vegetables was lower among South Asian groups than the mainstream white population while South Asian children report higher consumption of dietary fat. The Health Survey for England (2004) found both men and women in South Asian groups have lower levels of activity than the population as a whole and a number of smaller studies show that UK South Asian children and young people do less physical activity than their white counterparts (Broderson, Steptoe, Boniface, & Wardle, 2007). These figures are of particular concern when the relatively young age profile of the South Asian population in the UK is considered. This suggests that unless this relative burden of ill health and unhealthy behaviours is addressed, it will have a dramatic effect on both South Asian communities and healthcare providers in the next century.

Accordingly, whilst I came to this study readied with some information about the community that helped me identify areas of interest I endeavoured to be reflexive about my research interests and the position I took. As Cresswell (2001) suggests a reflexive researcher acknowledges their own positioning and their background shapes their interpretation. They position themselves to acknowledge how their interpretation flows from their own personal, cultural, and historical experiences.

1.2 Aims and choice of methodology

I sought a study design that did not position South Asian parents as the problem, or as more or less problematic than non-South Asian parents in the UK, so rejected suggestions to carry out a comparative study between UK South Asian and White British groups. I wanted to treat South Asian as normative, not as 'the other'. UK South Asians are the largest minority ethnic group in the UK and deserve a focus in their own right and because of their genetic predisposition to certain diseases there are specific health risks to the UK South Asian population which limits comparison with other UK populations. I aimed to deliberately place South Asian parents and their experience at the centre of the research activity, to explore commonalities and variations amongst South Asian parents. As a component of the Health Psychology doctorate I completed a review of available qualitative literature for health beliefs and perceptions specific to UK South Asian adults in relation to lifestyle related disease

(Lucas, Murray & Kinra, 2013) providing me with insight into the social and cultural constructs underlying perceptions. The studies available drew mainly from first generation UK South Asians migrants already living with a lifestyle related disease so provided a limited view.

The study aim is to explore and examine what living a healthy family lifestyle means to South Asian parents with young children in the UK. Also, to enhance understanding of these beliefs and perceptions to inform behaviour change interventions to reduce risk of lifestyle disease early. Understanding health and wellbeing requires understanding of people, place and life course as Paul (1995, p.1) describes;

‘Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another, what functions they perform, and what they mean to those who practice them.’

For this reason, a qualitative investigation was chosen to allow me to discover the way individuals construct and understand their ideas about a healthy lifestyle and to gain a detailed and contextualised understanding of the area. The study aims to make theoretical and methodological contributions, and for this reason grounded theory methodology was employed to enable generation of a specific theory containing not only the participant’s language but also their issues concerning health behaviours.

1.3 Overview of the literature

Grounded theory requires that a detailed literature review come after the data has been collected when tentative theories or concepts have started to form. The purpose of avoiding any specific and in-depth literature review prior to conducting the study as is required by most research methods is because Glaser (1998) argues that a literature review may result in external rhetorical jargon impinging upon the research. Delaying the review encourages the researcher to articulate their ideas (Charmaz, 2006). Rather than importing preconceived ideas and imposing them on the work. Thus, prior to the research, a number of areas of interest in the literature concerning health behaviours and lifestyle related disease in UK South Asians are

visited and directed towards a review of existing information. This facilitates my initial ideas to be situated within the wider context of the topic area and provides the reader with an overview of the research area conceptualised within a broad context. Here I present an overview of literature on the topic of lifestyle, disease and health behaviours and a description of key psychological theories of relevance.

1.3.1 Lifestyle related disease

Illnesses associated with a poor lifestyle are becoming more prominent in the UK with an increasing recognition that these are having a considerable impact on both an individuals and the population's health. These diseases are non-communicable diseases such as cardiovascular disease, type 2 diabetes, some cancers and chronic lung disease and are the leading cause of death in the UK and a public health priority. The term 'lifestyle diseases' is now commonly used as the majority (up to 80%) of premature deaths from these diseases could be prevented through lifestyle changes by tackling poor diet, tobacco use and lack of physical activity (World Economic Forum, 2011). The term 'lifestyle diseases' implies that not only are there a number of diseases that have in common a behavioural influence in their development, but also that there are behaviours that collectively contribute to a 'lifestyle' (Thirlaway & Upton, 2009). Lifestyle is a concept which has come to refer to people's styles of living, which, in turn, are shaped by their patterns of (behavioural) choices from the alternatives that are available to people according to their socioeconomic circumstances and the ease with which they are able to choose one over another (World Health Organisation (WHO), 1986).

Healthy lifestyles incorporate elements such as appropriate intake of healthy food and participating in recommended amounts of physical activity (Cross Government Obesity Unit, 2010). Following these healthy lifestyle principles is paramount to maintain good health and prevention of overweight and lifestyle related disease. However, as recognised by the WHO (1986) lifestyle is more than simply an individual choice. The way we live has economic and cultural dimensions and therefore as would be expected lifestyle diseases are not evenly distributed across the nation; the influence of social class, gender and ethnicity have all been implicated as important influencers of risk (Graham, 2009).

1.3.2 Ethnicity and lifestyle disease

Ethnic minorities in the UK account for almost 14% of the population (Office for National Statistics, 2011). Large scale surveys such as the Health Survey for England have shown that minority ethnic groups experience higher rates of disease and poorer health related outcomes than the White British population. In particular risk of non-communicable diseases such as cardiovascular disease and diabetes are higher in these groups (WHO, 2013). These health inequalities are defined by the WHO (2010) as differences in health status or in the distribution of health determinants between different population groups. There is evidence that some of these health inequalities may be widening (UCL institute of Health Equity, 2012) for instance the British Heart Foundation (2009) found rates of cardiovascular disease have been falling among White Europeans in the UK since the 1970s, but the same rate of decline has not been seen within minority ethnic groups.

The difference in prevalence of lifestyle related conditions between ethnic groups can only be explained by a complex and as yet unexplained interplay of genetic susceptibility and environmental factors (Barnett et al., 2006). These factors range from genetic predisposition, diet, lifestyle and psychological stress, to access to health services, housing conditions, education level and household income. The rates of overweight and obesity have been implicated in this difference and while rates have been rising in the UK for decades, including of most concern among children, there are signs that this may have slowed amongst some groups but not all. Over the time period covered by the NCMP (2006-2013), socioeconomic inequalities appear to have widened and the apparent year on year increases in obesity prevalence observed among Asian children in Year 6 may be greater than those observed for the White ethnic groups (Health and Social Care Information Centre, 2014). There is no straightforward relationship between obesity and ethnicity (Government Office for Science, 2007) refers to a complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain. However, physical activity and dietary intake are important factors and there is growing evidence that the differences in chronic disease risk between ethnic minority groups and white Europeans may originate

early in life. For example, children from ethnic minority groups in the UK engage in lower levels of physical activity than their white peers, (Khunti, et al., 2007). A reliable estimate of the extent to which ethnic specific differences in physical activity and other health behaviours account for the difference in obesity and the risk of developing diabetes and other lifestyle related diseases has not been established. This is due to lack of evidence from studies using robust measures of health behaviour.

Minority groups, whether they be defined in social, cultural or ethnic terms may hold values which differ from those of the dominant culture and this is reflected in their beliefs, attitudes and practices related to food (Fieldhouse, 1995) and physical activity which may affect their health status. It is also important to consider that health behaviours, both across and within minority ethnic groups within the UK, vary widely (Government Office for Science, 2007) according to different religious, cultural and socioeconomic factors, as well as geography.

1.3.3 Behaviour change theory

Becoming healthier in one's lifestyle does presume an understanding of what constitutes a healthy lifestyle. Certainly, current guidelines are available to the public to inform them of 'best practice' behaviours in terms of food, alcohol and physical activity. Sources include the Department of Health, Food Standards Agency, newspapers, magazines and NHS leaflets and for example the 'eat well plate' (Food Standards Agency, 2014) that indicates the main food groups that individuals should be consuming daily. However, with copious information about health promotion available, relatively little is available to help people sort through information, let alone apply it to his or her own lifestyles. A fundamental premise of health promotion is that people ought to take control over their actions, that once people are informed they can make healthy choices and lead healthy lives. However, to emphasise these lifestyle factors in isolation from their social context is, given what we know about lay health beliefs, somewhat artificial (Korp, 2010) and influencers of behaviour can theoretically include a wide range of factors, such as biological characteristics, personality characteristics, family, peers, the community, society and the built

environment. Some of these social and demographic factors have been integrated with the psychological factors to create psychosocial models to predict behaviours and develop theoretically based interventions.

The reason why individuals do not follow healthy lifestyles, or are unable to make changes to their lifestyle behaviours is therefore an important area of research. Health psychologists and health professionals have employed social cognition theories and concepts to predict, explain and increasingly underpin interventions to change health behaviours. The social cognition models present a number of factors for consideration as moderating variables in the behavioural change process. No single model or theory has been successful in predicting actual behaviour change. However theory provides an organised set of interrelated ideas, definitions, and propositions allowing for a systematic way of understanding situations. Theories of behaviour can be classified under various different headings based on considerations such as what are the key determinants contained in the model (e.g., values, attitudes, self-efficacy, habits, emotions), the scale at which the model can be applied (e.g., individual versus organisational/societal), or whether it focuses on understanding or changing behaviour (Darnton, 2008).

Social cognition models of health behaviour posit a range of factors that appear to influence behaviour, including perceived threat (e.g. perceived severity of and susceptibility to disease), perceived response-efficacy (e.g. confidence that engaging in a recommended behaviour will reduce the threat of disease), and perceived self-efficacy (i.e. confidence in personal ability to carry out the recommended behaviour). Because a prerequisite of a number of these cognitions is knowledge or awareness of the association between the disease and the behaviour, ensuring public awareness of the links between common disease and lifestyle is a necessary, step towards helping people to understand the potential health consequences of their actions, and towards encouraging them to take risk-reducing action and make currently much needed changes to their lifestyle.

Generally, the main theories of behaviour change include a concept relating to confidence and motivation, formation of goals and intentions. The concept is variously called self-efficacy in the Health Belief model (Rosenstock, Strecher &

Becker, 1994) and social cognitive theory and perceived behavioural control in theory of planned behaviour. Many psychological theories identify motivation as an important behavioural determinant. The term 'motivation' is used to refer both to our reasons for action (what is your motive?) and to our enthusiasm for doing it (how motivated are you?). Theories identify different features that influence motivation including conscious and subconscious processes, internal and external drivers, different beliefs about the consequences of their current behaviour, the likely outcomes of the new behaviour and perceptions of social norms including others attitudes and behavioural approval. Some theories emphasise the cognitive antecedents of motivation such as knowledge, attitudes and beliefs.

Behaviour change theory in particular highlights the role of deliberation and elaboration in achieving change. Put simply, change is considered more likely to occur and to be sustained as the amount of reflection about specific behaviours or issues increases. These theories theorise a greater or lesser impact by external factors such as culture, but each view behaviour to be a product of competing influences balanced and decided upon by the individual placing significant emphasis on individual action. Within this, individual behaviour is conceptualised either as somewhere on a continuum, or at a particular discrete stage of adopting a behaviour. The transtheoretical model (Prochaska & DiClemente, 1983) for example describes behaviour change as progression through a series of stages: pre-contemplation (no intention to change behaviour), contemplation (intention to change in the near future), and preparation (ready to change), action, maintenance, and relapse.

Social cognition models have provided us with useful information about key factors involved in deliberate decision making about lifestyle behaviours. The fact that they commonly explain less than half of the variation we see in health behaviours may be explained by the other roles that these lifestyle behaviours play in people's lives; by the fact many lifestyle behaviours are habitual rather than deliberate and because change decisions will be influenced by both intuition and emotion as well as by cognitions. There is also widespread recognition of the 'intention-behaviour gap', which describes the discrepancy between stated intentions and actions (Rhodes & de Bruijn, 2013). Crossley (2000) describes mainstream health psychology's theoretical models as producing an image of the individual that is overly rational and

thus inadequately psychological and social. Mainstream theories of health behaviour specify only a limited subset of cognitive determinants that are assumed to be most proximal to the behaviour and often assume that if you give people information they will act upon it. Such models fail to incorporate the structural dimensions of social action and may therefore be counter-productive (Naidoo & Wills, 2009) particularly if they fail to take account of the sociocultural variations in health beliefs and practices. A more complete explanation of particular health behaviours is necessary by extending theories to include other determinants relevant to a particular group. Theories in behavioural science have contributed substantially to our understanding of behaviour and promoting healthy lifestyles providing rich insights into why we behave as they do and have also suggested new ideas for how we might help people to make changes to those behaviours, for example to improve their health. As Michie et al. (2008) notes theory provides a helpful basis for designing interventions to change behaviour but offers little guidance on how to do this. When applying theories it is important to consider that multiple theories can inform model development. Health behaviour change theory provides a roadmap to the major factors that influence behaviour, articulates the relationships among the various factors, and considers when, where, and how these factors operate. Theories should be seen as a guide for designing models for interventions and evaluating outcomes.

1.4 Emergent research concepts and questions

As specified in the introduction to this chapter, whilst undertaking an initial review of literature for this study, it was not my intention to establish a preconceived conceptual framework, a research focus or questions. I have instead sought to trace that which I had previously known on the subject matter through my work as a health professional and researcher before entering the research field. By so doing I aimed to remain consistent with the established methodological approach which suggests that data collected would be analysed, interpreted and compared with the literature reviewed both before and after (Glaser, 1998). In contrast to this the later analysis (chapter 4) will integrate the data collected with any relevant literature, driven by the emergent research focus.

The key feature of this thesis by adopting grounded theory methodology is 'emergence', of both the research problem and research questions. No preconceived theoretical perspective was adopted prior to the fieldwork, but instead an area of interest was pursued. In doing so, the relevance of a grounded theory is earned, rather than preconceived. The aims of this study emerged from my own interests in the subject area and research problems and questions then emerged given my exposure to the concerns of South Asian parents, rather than professional interests preconceived by myself as the researcher.

There has been a growing recognition that disease is related to social and behavioural factors and therefore requires an understanding of how people maintain their health; in other words, examination of their lifestyles understanding why people might place themselves at risk of disease and why they adopt health protective behaviours. Hence by exploring current health behaviours, investigating parent knowledge of health behaviours and the implementation of this knowledge, in addition to exploring how families engage with healthy behaviours it may be possible to slow and preferably halt weight gain early within this group.

Within the literature reviewed, a number of limitations surfaced concerning the shortage of studies examining attitudes and beliefs towards health behaviours among the younger, currently healthy UK South Asian population. The South Asian population is heterogeneous (Bhopal, Unwin, & White, 1999) with significant language, religious, social and cultural differences among different groups of South Asian people. However, overall the evidence is consistent and robust: South Asian communities are at elevated risk of lifestyle related disease in the UK. A potential worsening of obesity related risk in South Asian children carries implications for persisting disparities in chronic disease across generations. Therefore it is advantageous to target this specific group for obesity prevention. Exploring perceptions in relation to this group's behaviours is a good place to start.

Chapter 2. Method

Choosing and understanding an appropriate research design is crucial for achieving the aims of the research. This chapter presents the research questions, an overview of the epistemological position of the research and overview of the methodology chosen. The next chapter on the research procedures and analysis describes how some of these aims changed as the research design developed but initially the aim was to carry out research with UK South Asian parents with young families investigating their health beliefs and behaviours.

2.1 Research questions

In grounded theory, research questions are statements that identify the phenomenon to be studied (Backman & Kyngas, 1999) and are always broad (McCallin, 2003). The way that the research questions are formulated in grounded theory studies reflects its methodological objective that grounded theory explains what is actually happening in practical life, rather than describing what should be going on (McCallin, 2003, p.203). The initial research aims that emerged are noted here:

- a) To understand what South Asian parents with young children consider living a healthy lifestyle for a healthy family.
- b) To identify factors that influence South Asian parents' decisions to engage in health behaviours for themselves and their children.
- c) To develop a theory around a behavioural model specific to UK South Asians for use in behavioural interventions to improve health outcomes.

2.2 Selecting a research methodology

A methodology provides justification for the methods chosen and is defined as analysis of the assumptions, principles, and procedures, in a particular approach to inquiry (Schwandt, 2001). To be able to evaluate research in a meaningful way, we need to know what its objectives were and what kind of knowledge it aimed to produce as this will modify and justify the knowledge produced (Carter & Little, 2007). Willig (2001, p.8) proposed the following three questions that helped me to identify a methodology's epistemological roots and the choice of methodology and

appropriate research methods:

- *How does the methodology conceptualise the role of the researcher in the research process?*
- *What kinds of assumptions does the methodology make about the world?*
- *What kind of knowledge does the methodology aim to produce?*

As presented in section 2.1 the current research questions are flexible and open-ended as useful with this under explored topic. This factor supports the choice of a qualitative research design as a qualitative approach best fits open-ended research questions (Barker, Pistrang & Elliott, 2002) rather than seek to test existing theories or determine relationships between variables. The immediate outcome of the research was to understand South Asian parent's perspectives on what a healthy lifestyle means to them and how this influences their family's health behaviours. Given this, a qualitative methodology was considered most suited to such aims due to its focus on understanding social relationships and the behaviour of groups where there has been little exploration of the contextual factors that affect individual's lives (Crooks, 2001). Furthermore enabling the generation of rich descriptions of experience and pursuing meanings rather than quantification (Langdridge & Hagger-Johnson, 2009). Compared with quantitative methodologies, qualitative methodology gives more freedom to participants to elucidate their ideas and respond in their own words (Barker et al., 2002). A qualitative methodology was therefore applied to enable a focus on the viewpoints of the participant and allow conceptualisation within a broad context based on meanings and understandings rather than on 'lifestyle issues' or 'problems'. With regard to the issue of research focus in grounded theory studies, the researcher begins with a general focus from the outset, given the nature of the unknown research problem (McCallin, 2003). In essence, it is likely to be exploratory because variables are unknown and concepts are gradually developed through the research process.

2.2.1 Epistemological stance

Consideration has been given to demonstrate research rigour in terms of the congruence between the research problem and questions as well as the ontology, epistemology, methodology and methods of data collection. A qualitative method, depending on its underlying epistemologies can be seen as positivist, interpretivist or critical (Klein & Meyers, 1999). By deciding the philosophical positioning for the study, this guided my choice of methods. An interpretive research perspective was adopted because like the research question in this study it attempts to understand that reality is a social construct of the participants involved and aims to construct interpretations of practices and meaning (Orlikowski & Baroudi, 1991). This perspective is in contrast to positivism as it suggests that the distinction between facts and value judgements are not clear (Carson, Gilmore, Perry & Gronhaug, 2001) and instead what people know and believe to be true about the world is being created out of evolving meaning systems that people generate as they socially interact (Neuman, 2003). A positivist paradigm is where an objective social world is assumed to exist independently and grounded theory methodology places its emphasis on constructing interpretations and fits well with the fundamental concept of the interpretive perspective, which is the social construction of reality. Interpretive researchers seek explanation via the realm of individual consciousness and subjectivity, within the frame of reference of the participant as opposed to the observer of action (Burrell & Morgan, 1979). Therefore, my job as researcher is to understand the meanings of human interactions in everyday life and the beliefs I bring to that process.

2.2.2 Methodology choice

Grounded theory was chosen as the methodology as it provides for the systematic generation of theory from data acquired by a rigorous research method (Glaser & Strauss, 1967). Grounded theory was attractive as in contrast to other methodologies it aims to move beyond rich description to produce theory grounded in the data generated by participants. Like other qualitative methodologies grounded theory emphasises understanding the 'voice' of the participant but is distinct in that it then uses this to build a theory about phenomena. I considered that the appropriate

research methodology needed to have processes for gathering, analysing and presenting data that agreed with the research questions. Therefore this choice was also based on the research question and aims, the viability of using such a methodology within the specific research context, and the specific guidelines for data analysis that it offers. Grounded theory fitted my research problem as like Carson et al., (2001) suggest the research problem included three characteristics that make grounded theory applicable. The first of these is that the research is interpretivist; the second is that the research is about complex social processes between people and finally there is virtually no existing theories about the phenomena or existing theories are demonstrably inadequate.

There are commonly three versions of grounded theory in the methodology literature including the original version by Glaser and Strauss (1967), Strauss and Corbin's (1990) proceduralised version of this; and Charmaz's (2006) constructionist approach. There is a lack of consensus on which version should be used due to a whole range of social science paradigms, academic disciplines, fields of study and associated questions that researchers identify themselves with (Wells, 1995). In spite of diverging methods used under grounded theory, the literature indicates some agreement concerning specific features of the methodology. Although, these may be implemented differently, these features have been identified as the following:

- Theoretical sampling
- Constant comparative analysis
- Coding and categorisation of data
- Memoing
- Theoretical Development

For this study, the approach proposed by Glaser known as the classical (Glaserian) version of grounded theory was chosen as it aims for a conceptual understanding of social behaviour, rather than the constructivist focus on interpretive understandings of participants' meanings. Classic grounded theory aims to identify a pattern of behaviour that transcends empirical difference in order to provide a conceptual,

rather than descriptive or interpretive rendering of participant behaviour with the potential to assume any theoretical perspective. This version was chosen over Strauss and Corbin's version as they impose too strict structures on the use of existing literature and data collection methods and analysis, which may force the concepts into a preconceived mould (Urquhart, 2013).

The purpose of grounded theory is not to tell participants' stories, but rather to identify and explain conceptually an ongoing behaviour that seeks to resolve an important concern (Glaser, 2002). Essentially, the findings of a grounded theory study are not about people, but about the patterns of behaviour in which people engage. Indeed, the main concern conceptualised in the grounded theory may not have been voiced explicitly by participants, but instead abstracted from the data in which the concern was acted out all the time (Glaser, 1998). In attempting to address the real concerns of participants, using whatever perspectives and methods will best address the purposes of this research, to generate a theory.

Classic grounded theory is more aligned with seeing philosophical positions not as discrete incompatible opposites but as offering multiple and complementary approaches to understanding social phenomena. I was keen that the findings should have a practical application attached to them, specifically that the outcomes could be utilised to both understand and work with individuals in a way that incorporates their beliefs and values to promote healthy lifestyles to this group. Grounded theory is appropriate for this inquiry as its systematic approach to data collection and analysis will result in a theory that reflects the central areas and factors that influence the participants' lifestyle choices. Not only was the aim to understand how the research participants perceived influences on their family's health behaviours, but also to present their views and experiences in a rich and considerate way. Accordingly, grounded theory is appropriate for investigating phenomena that as yet, lack a strong theoretical framework.

2.2.3 Reflexivity

It is important to be reflexive when conducting research about the process of critical self-evaluation on my biases and theoretical predispositions. My personal

experiences informed the methodological choices as I was aware that as both trainee psychologist and member of the hegemonic white British group, I have greater social power regarding access to discourse production (Van Dijk, 1996). For example it is I, not the participants who sets the research proposal. It was therefore important to me to assume a methodological approach that would go some way to minimising this power difference and allow for openness and flexibility, rather than predetermining the questions to be asked or the framework into which the data gathered would be organised.

Having been recently exposed to a number of theoretical strands in the literature on UK South Asians, this acted as guiding initial interests and provided points for developing, rather than limiting my ideas. Prior to starting my research I did not formulate the research focus through the identification of any gaps in the existing literature. Instead, research participants will talk about their views on a healthy lifestyle for a healthy family and share with myself narratives of significance to them.

2.3 Grounded theory procedures

Grounded theory has been applied diversely yet it is often a misunderstood methodology in qualitative research (Suddaby, 2006; Shah & Corley, 2006). This is in part due to the degree of flexibility it offers tools to use rather than recipes to follow (Charmaz 2006). Disagreements around grounded theory can make it difficult to obtain a clear understanding of what the process for the researcher essentially entails. However, with detailed and critical engagement with the literature on the methodology I was able to reach a resolution about my position and enable me to deal with ambiguity in the research process. Walker and Myrick (2006), and Urquhart (2013) were useful in helping me to clarify the differences between the approaches to grounded theory and preparation as using a grounded theory approach has major implications for planning, managing and executing the study.

As Glaser (1992, p.16) states, grounded theory methodology is 'a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area.' There are similarities between grounded theory procedures and those of other methodologies,

so outlining the methodological procedures of grounded theory is important to provide consistency in the use of terms and definitions throughout the study to remain as close as possible, to those originated by Glaser (1978).

2.3.1 The relationship between grounded theory and existing literature

As described in section 1.3 while engagement with existing literature prior to beginning the research is characteristic of most approaches of inquiry, Glaser and Strauss (1967) argue against this approach. As McCallin (2003, p.63) describes, the central concern is that the researcher may be side tracked by received knowledge and interpretations that support taken for granted assumptions, which are not relevant in the new area of study. Nevertheless, no researcher can be devoid of knowledge on the topic area whether it be closely associated or vaguely linked to that topic under study. According to Backman and Kyngas (1999, p.148), 'the researcher must identify and suspend what he/she already knows about the experience being studied and approach the data without preconceptions'. This means that researchers should not allow preconceived constructs and hypotheses to guide data collection. Glaser (1998, p.120) suggests that one way for researchers to deal with this is to establish and state the assumptions they absorbed from the literature so they become part of the data to be constantly compared with what is really going on. Smith and Biley (1997) discern that general reading of the literature can be conducted to aid two purposes: acquiring a feel for the issues at work in the subject area; and identifying any gaps to be filled by one's grounded theory study.

Being aware of the significant literature prior to the research enables me to approach the substantive area of study with some background knowledge and as Giles, King and De Lacey (2013) describe a preliminary review may enhance theoretical sensitivity and rigor and lead to innovative insights. Following on from the initial literature review when the grounded theory has reached its theoretical saturation, the literature search and review in the related central areas can be achieved at greater depth and intertwined into the theory as more data for constant comparison.

Reading and using literature in this way permits the researcher to remain as free and

open as possible to the discovery and emergence of concepts, problems and interpretations from the data (Glaser, 1998).

2.4 Evaluating grounded theory studies

In terms of evaluating grounded theory research, whether the process or outcome, there is no clear agreed set of criteria although not surprising given the variety of approaches. However, more recent developments suggest that those who read and conduct research need to engage the quality issue at a more practical level by considering how the research methods themselves can contribute to the quality of the research study (Elliott & Lazenbatt, 2004). In relation to grounded theory, this requires that the researcher identify essential features of grounded theory research and the link between the research methods and the quality of the research study. According to Glaser (1998), the evaluation of grounded theory is based on a standalone set of criteria, which are: fit, workability, relevance and modifiability.

Grounded theory studies need to be evaluated in order to make decisions about whether to apply the research findings considering how the research methods themselves can contribute to the quality of the research study. Within a qualitative research tradition the researcher usually relies on respondent or participant validation as a way of checking the researcher's interpretation of data. Participant validation involves the researcher returning to the participants and checking the accuracy of individual interview transcripts with participants or checking that the researcher's interpretation of the data represents what they said or their experiences (Seale 1999). One of the problems with triangulation is that it produces yet another layer of data, which again needs to be analysed. It is generally accepted that the methods of respondent validation, whilst intended to counter subjectivity, are themselves open to problems that limit the extent to which the accuracy of the research findings can be assured (Seale 1999; Sandelowski 1998). Therefore the value of the grounded theory methods of constant comparative analysis and theoretical sampling is that they provide an integrated research approach to data collection, analysis and checking the quality of research findings.

2.5 Summary

A grounded theory methodology will be undertaken of beliefs and perceptions held by UK South Asian parents around a healthy family lifestyle. The study will aim to develop a theory that can be used to define specific objectives meant to alter the hypothesised mediators in a way that leads to effective behaviour change for this population. The next chapter details the procedure for the research methods and the key processes involved.

Chapter 3. Research procedures

This section outlines the procedure for the research methods, including the delivery of key concepts, initial data collection, the sampling technique employed, and the process of participant recruitment. The data collection methods and procedures are also discussed along with the data analysis methods.

3.1 Participants

The study aim was to interview parents of South Asian heritage living in urban areas in the UK. Participants needed to have at least one child between 5-12 years of age (an age where children have developed habits but where parents normally still have a high level of input into their lifestyle) and be able to speak with proficient English (for the benefit of the study).

Inclusion criteria

- Ethnicity stated as South Asian
- Parents with at least one child between 5-12 years of age
- Parents live in an urban area
- Agree to sign consent form

Exclusion criteria

- Initially fathers were invited but later excluded
- Not proficient in English

3.1.1 Selection and the process of sampling

Grounded theory uses non-probability sampling, where the sample numbers or data sources are unknown at the commencement of the study. In accordance with the prescription of Glaser and Strauss (1967) the sampling then becomes theoretical, rather than purposive, in that the sampling is determined by the emerging theory after the initial sample is selected and the initial data collection and analysis has been undertaken. Qualitative researchers frequently use purposive sampling as a method for increasing knowledge and deliberately seek participants who are known

to be rich sources of data. Glaser and Strauss (1967) note that different groups of people help generate categories by highlighting both differences and similarities. Before starting data collection it was hard to see what manners of variability might be significant. For example, how parents of a different subcultural group or generation of migration might see the questions or whether age, education, religious belief or home location might elicit different categories. Early sampling aimed to create some boundaries by indicating variance or similarity between categories although each of the mothers brought their own combination of life experience, knowledge, and reflection to the interviews.

For the initial sample 'networking' was used, a form of snowball sampling (Kuper, Lingard, & Levinson, 2008). Individuals I knew of who worked with South Asian communities were contacted and asked to share the research flyer (Appendix A, p.216) with parents who have young children. Colleagues gave me details of parents who described themselves as willing to participate and whom I then phoned to explain what their participation would entail and if in agreement an interview date was arranged. The first conversation over the phone was informal so that the potential participant could get to know me as a person, as well as to give me the opportunity to explain the research and discuss the information sheet (Appendix B, p.217) and consent forms (Appendix C, p.219) they would receive. Within this call eligibility was confirmed and once agreed arrangements were made to meet them at a time and location convenient for them, which included their home, local community or children's centre. Interest was typically from mothers not fathers and of the fathers interested finding a suitable time to meet me due to their work, religious and family commitments was difficult and ended in numerous cancellations on their behalf. After the initial three interviews I repeated this process and contacted individuals to remind them about the study and to ask eligible parents if they would be interested in taking part and referrals were received this way. Also, the participants interviewed were asked about (and often actively suggested) friends who may be interested in taking part extending the network. At this stage I decided to change the inclusion criteria to mothers only and exclude fathers as I was aware that their roles within the family and subsequent health behaviours were likely to be very different.

3.1.2 Participant profile

Participants in this study were all female (see table 1) and type of South Asian origin was as follows: Afghanistan (n=2), Bangladesh (n=1) and Indian (n=4). Only one participant was not born in the UK. All participants lived within urban areas of east or north London in communities where similar groups of ethnic minorities dwelled. Three participants worked part-time and four participants were home-makers.

Table 1. Participant profile

Participant	Generation of migration	South Asian origin	London borough of residence	Number of children	Age range of children	Religion	Health issues
1	2 nd	Bangladesh	Tower Hamlets	4	8-23	Muslim	Type 2 diabetes / High blood pressure
2	2 nd	Afghanistan	Islington	3	2-6	Muslim	
3	1 st	Afghanistan	Camden	3	7-12	Muslim	High cholesterol
4	3 rd	India	Hackney	2	4-7	Muslim	
5	2 nd	India	Hackney	3	7-14	Muslim	
6	2 nd	India	Hackney	4	12-21	Muslim	
7	3 rd	India	Hackney	4	3-12	Muslim	

3.1.3 Ethical considerations

Ethical approval was obtained from the London Metropolitan University Ethics Research Committee prior to study commencement. Participants were provided with an information sheet explaining the aims and purpose of the study and the methods of data collection they may be required to participate in. All were personally spoken to and given the opportunity to ask questions prior to signing a consent form. They were also informed that they were free to withdraw from the study at any time and in the event of this any provided information would be destroyed at their request.

Those willing to participate were asked to suggest an appropriate venue. Individually signed informed consent was obtained from all participants. Given the potential language issues, particular care was taken to ensure participants clearly understood the nature of their involvement in the study. It was essential that all participants were aware of the aims and purposes of the research, and that they were clear that participation would not be to their detriment. As a researcher exploring a culture different to one's own caution was practiced with an increased awareness of personal limitations. When needed, advice was asked of those involved in work with and from the South Asian community to improve my own knowledge and understanding.

With the participant's permission the interviews were digitally recorded and transcribed verbatim. Pseudonyms were used to identify each of the women in the study and used throughout the report to preserve confidentiality and anonymity of the participants. All data was held on a secure, password protected computer and participants were identified by a non-identifiable code as required by the Great Britain, Data Protection Act (1998). Identifiable data (e.g. contact details) were held on a separate database and used only to contact the participant about the study. Confidentiality is critical in any study but particularly for minority groups who may belong to small, local communities, therefore participants were reminded that confidentiality would be guaranteed in any emerging reports from the study.

During the interviews questions were raised by participants about their risk of diabetes. Therefore, following their participation I arranged a diabetes education and risk assessment session run by local lay diabetes educators. The participants along

with other local mothers were invited to attend this 'women only' education session at a Children's Centre.

3.2 Data collection

Through the use of grounded theory methods, as the researcher I adopted a flexible approach to data collection rather than being constrained by a rigid prescription of methods. This allows the emergent data to guide future data collection strategies in accordance with the direction that the data is taking. As expected this flexibility of methods has resulted in grounded theory researchers collecting data through the use of a wide variety of data collection methods. Wimpenny and Gass (2000) suggest that it is important for the researcher to ensure that data collection methods adopted is appropriate to the research methodology. In this study, I gave consideration to the chosen methods of data collection, namely semi-structured interviews to ensure congruency between elements in the research design.

3.2.1 Interviewing as method of data collection

Interviews are widely used in qualitative research and interviewing is suggested as the most appropriate and commonly used method of data collection in grounded theory research (Charmaz 2006; Goulding 2002). This is because respondents' perceptions and beliefs are at the heart of qualitative research and interviews lend themselves to capturing this with questionnaires for example, the respondent's motivation is difficult to assess, affecting the validity of response. Focus groups may not be effective due to participants feeling uncomfortable explaining lifestyle choices in front of others who they may feel judge their choices.

Within the context of grounded theory, the interview is guided by theory development and the ongoing analysis will influence the questions that are asked, with the direction of the interview becoming driven by the emerging theory. The questions were designed to identify patterns and common themes in the participants' accounts and sought to identify the meaning of a healthy family lifestyle to participants. Interviews in grounded theory studies are relatively unstructured, although it can be

argued that they become increasingly structured as the researcher seeks to explicate emerging concepts in accordance with theoretical sampling. Even in unstructured interviews interviewing may be conversational but as the interviewer I have some level of control, so it is never just a conversation. The rationale for qualitative interviewing is based on the idea that people are experts about their own experience and so are best able to describe how they experienced a particular event or phenomenon. Fielding and Thomas (2001), argue that probing needs skill because it can easily lead to bias. Probing skills are important as trust and rapport must be established to facilitate self-disclosure. Establishing a rapport with the participants was critical in getting them to talk openly about their experiences. Although the participants in this study were undeniably central to the phenomenon being explored, the main aim was to understand their perceptions and experiences. They were not necessarily knowledgeable about it in so far as they were not used to reflecting on the topic and discussing and explaining it with a stranger. As an interpretive researcher I look to understand the participant and to see effects and power where subjects might only see emotion and personal meaning.

3.2.2 Development of interview guide

In this study, a variety of probing strategies were used to encourage parents to reflect and articulate their opinions, thoughts and experiences of living a healthy family lifestyle. In the first set of interviews to facilitate each individual interview the participants were asked a series of questions as part of a semi-structured interview process. To assist in the process, a topic guide (Appendix D, p.220) was employed which did not remain static but was developed as the interviews progressed (Appendix E, p.222). The topic guide was not comprehensive and centrally contained only a number of general issues. The reason for this was to see how the research participants understood the question, and how they conceptualised the issues to avoid forcing the participants into categories determined (consciously or unconsciously) by the interviewer. Also, it gave participants the power to determine how much personal information they shared and at what point. In practice, some participants went straight to their own experience, while others started by considering the questions at a broad or abstract level sometimes referring to the

experiences of extended family members or their community. The participants shared personal information such as worries they had for their family's health. Some participants commented positively that they found the interview had given them an opportunity to reflect on their current family health behaviours and consider opportunities for where they could be healthier.

A pilot interview was conducted with a participant who fit the sampling criteria prior to commencing formal interviews. The purpose of this was to develop interviewing technique and to see how this participant responded to the questions. The pilot interviews showed that an undirected interview structured around very broad questions could produce rich and relevant data. Therefore, in the early stages of the interviews this less structured questioning approach to elicit the participant's perceptions of the experience was used. As the interview progressed open ended questions were sought to deepen the emergent theory, which had been elevated through the analysis of previous interviews. The increased structure was the result of theoretical sampling and the need to go on to validate a construction of themes from already collected data. The opening question in the interview was the same open question, 'What is your idea of a healthy lifestyle for your family?'. This approach supports the development of a rapport with the participant as it allows the participant to define the initial topic area that they are comfortable raising. In turn this rapport supports me as the researcher to gain data related to the participant's experiences.

3.2.3 Interview Process

A total of seven interviews were conducted and took place over a 4 month period, between December 2012 and March 2013. All interviews were undertaken in suitable locations in order that a relaxed atmosphere, conducive to such meetings, should be created including participant homes (2) and community centres (5). At the outset, all participants were assured of confidentiality and that they could withdraw and terminate the interview at any time should they wish to do so. They were also encouraged to critique any interview questions asked if they felt the need to do so.

Interviews were recorded, with permission, on a digital voice recorder and at the end of the interview participants were given a debrief sheet (Appendix F, p.223).

The interviews flowed freely, taking from 40 minutes to over 2 hours. During the interviews it was important not to restrain the participants but to give them time to talk limiting researcher participation to questioning, reflective listening, and reflective or clarification statements. The questions were asked in as non-directive a manner as possible to meet the study's principal aim of learning about the interviewees' perceptions. The data collection and analysis for this project took place in alternating sequences and was guided by the grounded theory methodology. This meant that the interviews were transcribed and coded immediately after they took place. Hence, initial findings from interview coding could help to shape the questions for subsequent interviews. As the data collection proceeded I sought to flesh out emerging concepts and was comparing and contrasting participant's comments with data analysed from previous interviews in accordance with constant comparative analysis.

Following each interview notes were made on what in the interview approach had been successful or not. The interview recordings and transcripts were reviewed to ensure accuracy and to review interviewing. All identifying information (i.e. names, and places) was removed from the transcript, but transcripts were still kept in secure storage during the research, and recordings kept on a secure hard disk drive. After the early interviews, changes were made to the interview guide. As Creswell (1998 p.19) remarks, 'our questions change during the process of research to reflect an increased understanding of the problem'. Transcribing was itself part of the data analysis process and allowed the opportunity to return to earlier interviews as new phenomena was identified; a process that afforded the opportunity to determine the context of the data. Furthermore, memos were written after each interview, where I noted my thoughts and impressions about the interview and possible emerging concepts (Appendix G, p.224).

3.2.4. Revising questions and theoretical sampling

As a result of identifying data gaps, and reviewing which lines of questioning had been most fruitful, I revised the central question of my research, changing it from, 'What are South Asian parents views of a healthy lifestyle?' to 'What are the factors influencing South Asian parents ability to provide a healthy family lifestyle?'

The first three interviews set the basis for the specific points to cover in the next interviews. They were helpful for identifying variation, and each participant brought not only different experiences, but also different perspectives on the research which helped shape my approach for the following interviews. Reviewing the first set of interviews, it was clear that questions needed to be better focused, so in the next set of interviews more focus was placed on what the participant believed influenced their family's health behaviours and the choices they made for their children's health. In this way I was seeking to understand the determinants of motivation to initiate and maintain health related behaviours.

To explore emerging concepts such as 'changing traditions over time,' parents from second and third generation only were sought, to see if similar concepts would continue to emerge. New codes did emerge, although many fewer than in the first three sets of interviews. Also, more appropriate codes emerged and reviewing and improving the coding on earlier transcripts took place. Following the fourth set of interviews, the codes were refined to produce a long list.

3.3 Analysis

This section reports on the analysis of the data collected during the interviews. The analysis was conducted in a systematic, non-linear fashion using the constant comparative technique of analysis where data analysis data collection, coding and analysis occur simultaneously. Although the analysis and results are written in what appears to be defined stages of a linear process, in reality this process is non-linear. During each phase of data analysis, new data, concepts, ideas and propositions were constantly compared with previous data. Each step of the process added to the integrity, accuracy and authenticity of the work presented.

3.3.1 Open coding

The interview transcript was comprehensively read prior to the process of analysis during which procedures such as open and selective coding were employed, in addition to memoing and eliciting additional questions for further theoretical sampling. The transcript was coded line-by-line, sentence-by-sentence or paragraph-by-paragraph in order to make sense of the data and to facilitate the emergence of preliminary codes, codes and preliminary categories through examination of the data. Coding the transcripts by hand was advantageous as it facilitated analysis and allowed more of the data to be seen and codes to be assigned simultaneously. This resulted in a more consistent assignment of codes as Glaser (1978) advocates as many interpretations as possible were made of the data. I continually asked, 'What is this data a study of? What category does this incident indicate? What category or property of a category, of what part of the emerging theory, does this incident indicate? What is actually happening in the data? What is the basic social psychological problem faced by the participants in the action scene? What is the basic social psychological process or social structural process that processes the problem to make life viable in the action scene? What accounts for the basic problem and process?' as Glaser (1978, p. 57) advises at the stage of open-coding. Sometimes the same section of text was assigned more than one code for example, where a question was asked of the participant's entire response and also where there was focus on only a couple of words within a response. Impressions and questions about codes were documented in memos throughout the analysis process.

Line by line analysis allowed careful comparison of new data with what was already coded (Glaser 1978). The next phase involved grouping together like words, concepts, sentences or paragraphs to form codes. In this phase of analysis where codes were emerging, the actual words or terminology of the participants were used to describe the code. During the analysis of the second interview, the data was constantly compared with the first to highlight incidents, events and areas of interest. Both similarities and differences are equally important so were noted and used later in the study to identify properties of categories and links between categories and the core category (Glaser & Strauss, 1967). Similar data is grouped together to form codes, preliminary categories and categories and dissimilar data contribute to the

emergence of the category properties and the links between categories (Glaser & Strauss, 1967). According to Glaser (1978, p. 49-52), the process of constant comparison involves four steps: the analyst compares (1) incident to incident; (2) the concept to more incidents; (3) concept to concept; and (4) outside comparison (e.g. anecdotes, stories and literature). In this study, each line of the transcript was coded and selective codes were then compared and integrated if necessary. Once a set of selective codes were used effectively to explain the shared process connecting the research participants, further instances in other participant interviews relating to these codes were identified and coded in order to ensure saturation of the code by participants.

The initial coding process was challenging as this was my first experience using grounded theory and at times I had concerns about coding consistency and the large number of codes generated. The process of initial coding produced 142 codes (Appendix H, p.226) from all the participant interviews. Although I was aware that having a large number of initial codes renders analysis more complicated, it was important not to 'force' the data into emerging categories at an early stage. Many of these codes contained just a single segment of data while others contained multiple segments.

3.3.2 Memoing to develop and clarify categories

The extended coding process, as described in the previous sections, facilitated reflections on codes and categories, which were captured by writing memos. In conjunction with the constant comparative method of data analysis memos were written throughout the research to assist theory development. Memos were written as notes to myself and provided a means of documenting thoughts related to the codes, the emergent categories, and the interaction of the categories as the interviews and analysis progressed. These notes were recorded when they occurred helping me keep a note of thoughts without the pressure of having to immediately determine how ideas fitted within the overall research findings and analysis.

The memos were consulted when establishing links between categories and setting up the initial theoretical framework and used to assist in data analysis and

subsequent substantive theory development. The writing and reflecting on memos has been a crucial step in the development of the final categories based on open and selective codes. An example of an early memo around 'Not keeping to tradition': what role do traditions still have on lifestyle? Are the influences of tradition still visible? Or have they changed? Have new traditions occurred? Why? Memo's triggered analysis that led to formulating the core category. Later memos recorded more conscious analysis, especially questions and doubts about my interpretation of the data. Memos also arose from reading and discussions with people interested in the research topic, and acted as reminders to consider these concepts in later analysis. The memos along with codes and categories could then be used for constant comparison. The following chapter provides in detail how initial open codes developed into selective codes and finally to abstract categories.

3.3.3 Developing the categories and their relationships

The core category, which emerges as I constantly coded, analysed and theoretically sampled for more data and this data was consistently related to many other categories and their properties which emerge iteratively (Glaser, 1998). Selective codes were compared, integrated and conceptualised towards a more abstract level. The aim here is to achieve theoretical completeness which accounts for most of the variation in a pattern of behaviour conceptualised by a core category (Glaser, 1978).

Changing the central questions of study led to a step up in abstraction, as being able to see concepts at work made it possible to move towards the grounded theory model of concepts being abstract of place, time or people, not linked to one 'incident' or phenomenon, and having some 'enduring grab' (Glaser, 2002). Reviewing the list of codes, it became clear that some codes easily formed clusters (Appendix I, p229) for example, codes relating to various 'food traditions' (such as use of high quantities of sugar, salt and oil in cooking and the frying of foods) were merged, out of which the connection to the more abstract category of 'moving away from tradition' emerged. The next stage was to analyse the categories, breaking down the abstract ideas, comparing them, and establishing relationships. For this I drew on Glaser and Strauss's (1967) process of identifying the properties of categories by looking for

adjectives and adverbs which characterise categories and following Glaser's (2006) recommendation to use gerunds (the –ing ending, so 'description' becomes 'describing') as a way to focus on the action involved. Turning some codes into action statements proved effective in bringing out underlying processes and turning vague ideas into clear concepts so that, for instance the code, 'eating to excess' became the much clearer 'letting go'. Analysing the categories was constantly comparative, with each concept emerging from one category suggesting ideas in another, making the process much more fluid and creative than transcripts had indicated.

In developing categories, patterns in actions or concepts presented were sought rather than detailing the behaviour (Glaser, 1978). The research questions were directed at triggering participant's ideas of what they thought the patterns were, and even the first interviews produced conceptual abstractions as well as descriptions of behaviours and beliefs. Categorising involved looking for more abstract labels for clusters of concepts. Some codes clustered easily and higher-level labels emerged clearly from them, while others remained as outliers until final analysis. To explore the relationships between categories summary diagrams supported the analysis process. The first diagrams helped link categories, while later diagrams attempted to resolve the underlying shared processes. This process brought out hierarchical relationships between the categories, enabling me to find abstract concepts and elicit the conceptual categories (Appendix J, p.231).

Charmaz (2006, p.113) describes saturation as, 'the point when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories'. Data from the last two interviews helped identify comparisons, extend the scope of some categories and clarify concepts that had been unclear. By the seventh interview no new relevant codes were emerging there was enough data to provide detailed analysis of the categories. Once the core category and the shape of the theory had emerged, the literature was reviewed to see what could illuminate, either positively or negatively the developing theory.

3.4 Evaluating the quality of the research

In evaluating grounded theory research, whether the process or outcome there are no clear agreed set of criteria although not surprising given the variety of approaches. Glaser (1998) produced a standalone set of criteria to assess quality of the grounded theory which are: fit, workability, relevance and modifiability further described by Partington (2000, p. 93) as:

1. they would fit the real world;
2. they would work across a range of contexts;
3. they would be relevant to the people concerned;
4. and they would be readily modifiable.

Concerning fit, the results presented were derived in discussion with South Asian parents reflecting on their perceptions of a healthy lifestyle. Consequently, the proposed theoretical area fits well the empirical situation that has been investigated. Moreover, the data are emergent concepts related to current matters of the South Asian mothers interviewed (relevance), and the proposed theoretical focus can be constantly modified to fit and work with relevance. In a grounded theory approach, this means that research participants' concerns shape the direction and form of the research and the researcher seeks to learn how they construct their experience through their actions, intentions, beliefs and feelings (Charmaz, 1996). Although, I addressed these criteria as part of assessing the research quality, it is argued that it is more important to consider the research methods themselves from the perspective of quality in research. Hence I identified the essential components of grounded theory such as: concurrent data collection and constant comparative analysis; theoretical sampling; memoing; and more importantly I looked to understand how these research methods impact on the quality of the research. These methods are an integral part of the systematic and rigorous research approach of grounded theory. The Appendices further evidence the analytic processes by documenting extracts of coding patterns, additional quotes and memos. Memos for example I used to record the meaning of conceptual ideas and provide a track record of the analysis and eventually used as the analytical building blocks from which the theory is developed. One reason why I found writing memos important is that it encouraged

analysis that is grounded in the data because I had to consider how the codes and their properties relate to each other and provide evidence of this from the data. Glaser argues that this form of comparative reasoning undoes earlier assumptions because it forces the researcher to keep focusing on the data.

3.5 Summary

The data collection methods, procedures and analysis are presented here setting the scene for the data analysis and interpretation that follows in chapter 4. Although the discussion separates data collection and data analysis, data collection and data analysis were actually conducted simultaneously. Data analysis commenced immediately following the first interview and continued after each additional interview until completion of the study as per the grounded theory design.

Chapter 4. Research findings and analysis

The chapter opens with a diagram showing how the final categories interact to produce the theory. This is followed with a description and explanation of the categories, which were emergent from the data and their associated properties and dimensions, linking the findings in relation to the existing literature. In line with the interactive nature of the theory, material in this section is interrelated so that discussion of key findings is linked to comparable literature, possible implications for theory and practice, and research needs. This chapter then concludes with a description of how the final theory emerged and provides an explanation of how this theory developed and advanced. Whilst the emergent theory proposes a number of selective categories, there were over-arching themes interpreted from the interviews that emerged to form the theory.

4.1 Grounded theory model

Diagram 1: *A grounded theory of the balancing act South Asian mothers engage in to negotiate a healthy family lifestyle.*



Table 2. *Model components*

Model components	
1	Cultural identity / Barriers / Health beliefs the central phenomena influencing a mother's her family's health behaviours.
2	Negotiation of the central phenomena influencing health behaviours.
3	Balancing act of the central phenomena that needs to be negotiated for a healthy family lifestyle.

4.2 Key concepts

The grounded theory is underpinned by a number of categories including the three emergent categories: *cultural identity*, *health beliefs*, and *barriers* and the core category: *balancing behaviours for healthy lifestyle*. Following the introduction of each category an explanation is given of how they emerged from the data and there is a description of some of the characteristics or properties of the category presented, illustrated with quotations from the mothers who took part in the research. Each category is broken down into selective codes, which helped group codes into theory. The selective codes discussed within the category are presented with one or more examples of the words, concepts or sentences that emerged in each selective code. It is acknowledged that there is overlap in many of the selective codes as much of what the mothers relayed was represented in more than one code. The categories are not presented in a particular order due to their dynamic and interactive nature.

4.2.1 Conceptual category: Cultural identity

Cultural identity developed as a category out of certain overlapping cultural beliefs and values communicated through mother's lifestyle choices. Whilst mothers advocated a healthy lifestyle for their children and recognised a variety of health messages their cultural identity impacted greatly on their perceived control over behaviour. Key behavioural determinants included cultural influences on food traditions, hospitality and leisure time.

Selective code - Food traditions

Culture was expressed through food traditions and social norms imposed by cultural practices which readily influenced dietary behaviour at frequent social occasions. Whilst the role, type and function of some food traditions were linked to cultural identity and passed on from previous generations, other newer traditions were evident from the influence of the host country. Daily family routine consisted of western style breakfasts, lunch and snacks with eclectic culinary styles for evening meals. Mellin-Olsen and Wandel, (2005) found immigrants' breakfasts and lunches change whilst traditional foods are more likely to be retained at evening meals and at weekends, as this is when most of the family is present.

Belour: We would have more of an englishy breakfast when the kids wake up in the morning they will have a bowl of cereal then we will have eggs and toast with eggs or butter and jam and things like that Philadelphia, cheeses... (Line (L.) 197-201)

Naresh: Usually dinner...is something either pasta or something Asian like a curry and rice or curry and chapattis (L. 30-32).

In this study, first and second generation mothers cooked traditional meals at home more often than the third generation mothers. As Chowdhury, Helman, and Greenhalgh, (2000) found of UK South Asians different cultural practices and preferences can be seen between the generations with respect to food choice.

Ameena: I used to cook chapattis every morning.... I changed that to something like cereal...or they go for egg, bread, beans....They say "no mum (we want) brown bread and egg" but I think they should have curry meat and everything together as well that's got more spice in it. (L. 776-779)

Khatira (1st gen.): My children they do like when they taste other foods they ask you to make pasta that's not common in our culture.... or chicken nuggets... (L.385-389)

Many minority cultures assimilate to some extent into the majority cultural lifestyle through the process of acculturation (Phoenix & Husain, 2007) and move towards mixed food habits or a more 'Westernised' diet (Kumar, Holmboe-Ottesen, Lien & Wandel 2004) with culturally based foods often among the last practices people change through acculturation (Caplan, 2013). Reasons for acculturation around dietary choices included reduced preparation time, concern about their family's health, more conducive to healthier ingredients and cooking techniques, their family's preferences and display of acculturation.

Farida: I love curries and chapattis I do love it, but I can't be bothered making it and the chapattis process of making it....I try to do it once a week (traditional meal), maybe once every two weeks because we have it at my in-laws at the end of the day so what it is my husband is not too fussy thank goodness he is not a curry lover (L. 319-328).

Mothers felt that theirs and their children's engagement with British food culture was both negative and positive. Positives included liking the taste, reduced preparation time, low cost whilst negatives were focused on the unhealthy nature of foods and foods being processed. Interestingly one mother who had recently visited her country of origin was surprised to find fast food and high calorie snacks now being very common in urban areas.

Sabah: We try not to eat a lot of fast food maybe if we do its once a week or something but because they grab whatever and to be honest fast food is so cheap the healthy food is so expensive (L. 25-28).

Khatira: In our culture back home after dinner we just had raisins with almond with something but here you might have something like bakery and every sweet has cream on top and that's also somehow affected the order and the healthy side of that culture (L.793-798).

Also influential on food choice and consumption are cultural patterns of shared understandings. For example, when cooking for guests the use of sugar, oil and salt in large quantities and frying foods to ensure the look, flavour and taste of food. The tradition was viewed essential to providing high quality food and was a culturally accepted belief.

Radhika: I mean as Asians we tend to use quite a lot of oil in everything that we cook (L.16-18).

Farida: Our Indian diet is lots of oil and purified ghee which is purified butter and cream and things like that... (L. 124-126).

Food is often used as a means of retaining cultural identity but also influences which types of foods are considered healthy and unhealthy. For instance spices, ginger, garlic, regular consumption of meat, yoghurt and fruits ripened in their home countries were considered 'health giving' whilst very sweet fruits, nuts and fatty meats are to be eaten with caution.

Farida: One piece of fruit a day and I am trying to increase it but yeah they (her children) like their seasonal food their mangos from India...but they are also aware that mango can be very fattening as well if consumed too much because it has a very high sugar content (L. 294-298).

Ameena: If you don't have spice you get tummy ache and all that and if you are stronger you can actually take these spices and it's good for you like ginger, garlic they are the best for you.... (L. 974-975)

Naresh: I think my sleep, my diet everything I wasn't drinking any yoghurt drinks or yoghurt so I think these things especially affected my lethargicness and all that (L. 345-347).

Foods that demonstrate affiliation with a culture are usually introduced during childhood and are associated with security or good memories so are likely to be passed down from generation to generation (Caplan, 2013). For instance, having a 'sweet tooth' was seen as a shared cultural trait and was given as an explanation for the family's regular enjoyment of and cravings for sweet foods and drinks.

Belour: I have a really sweet tooth... Western sweet things like penny sweets that type of stuff and shoe laces and cola bottles and those types of things they are my weakness.... my son is exactly the same he will gorge on anything sweet. (L. 161-173)

Sabah: The worst thing is we are very sweet toothed in our house so it's not easy makes it harder (L. 211-213).

Farida: They need some kind of sugar content in their Weetabix or porridge (reason for adding sugar) (L. 68-69).

The special and plentiful sweet foods provided at social gatherings and religious events, were viewed as exacerbated their cravings.

Ameena: It's the culture...Indian sweets is a delicious dish...I used to have it every Ramadan we used to have every day with sweet like you have dessert we have sweet after its only that Ramadan that puts you onto sugary stuff.....when I am fasting I really need all that to get my energy I need something sweet. (L. 135-143)

Khatira: The table is full of all the sweet things and after food you are just enjoying these foods and it is difficult to stop yourself when your child is coming and somehow it is not their fault it is us actually so mainly culture and how to change that culture is the hard thing (L. 801-805).

Selective code - Value of hospitality

Hospitality is a highly valued aspect of the mother's culture with a high frequency of entertaining or being entertained (1-2 times a week). Bush, Williams, Bradby, Anderson, and Lean (1998) explored obligatory patterns of food intake in South Asians finding traditional family hospitality meals play a more important part in the life of migrant South Asians than they do in White and British born South Asians. The act of being hospitable is an influential part of relationships and a highly valued obligation as food was used as a means of its expression to show appreciation, kindness and respect. Therefore, to provide good hospitality mothers followed various customs such as providing appetisers or snacks on arrival, a generous meal with large portions, plenty of choice and catering to the guests' traditional or non-traditional tastes.

Belour: I grew up here so I you know like mashed potato and potatoes and things but if you served mashed potato to my aunt she would be like what the hell is this..... (L.152-155). I do make a spaghetti that they all kinda like with double cream and things like that but it's usually traditional it depends, it all

depends who's coming if it's people have been raised back home then traditional food but if my brother or cousins come over then it's mixed but usually English food (L. 217-222).

Mothers and their families were more often entertained in the homes of extended family members rather than entertaining themselves due to the pressures of providing good hospitality meals when they are busy with young children and/or working.

Farida: We go to my mother-in-law's one day and one day my mum's house (at the weekend) and that's when we probably have our fall-out Indian meal or then it's leg a leg roast or chicken roast or and that's with all the fattiness that's involved (L. 132-135).

The social nature of food meant that feelings and emotions other than quelling hunger were often linked with the provision of food. A recent review showed consumption of foodstuffs within UK South Asians plays an important role in social networks with the offering and receipt of food, the creation of social networks by 'gift-giving' in the form of luxurious or traditional food, and the social significance of cooking for guests and of celebratory meals (Lucas et al., 2013). Reinforcing factors orientate towards social outcomes with the involvement of the whole family and the bringing together of people. Within this environment mothers felt prevented from taking healthy measures (i.e. healthy portion sizes) for themselves and their children as their relationships with family and friends were inextricably linked within the social norms of consuming food (i.e. having second portions). Similarly, Grace et al., (2008) found what is accepted to be healthy among South Asians (small portion size, limited rich and fatty food) was seen as less important than the social norms of hospitality and the role of consuming food viewed obligatory otherwise they risked offence or alienation (Lawton et al., 2008).

Khatira: This is where things go wrong it's a part it's the whole culture you can't change it ...obviously they do treat you really nicely... and obviously it's a big portion it's not healthy (L. 37-42). Obviously if nobody's coming it's something really plain...when somebody's coming oh my god yeah we have about 4 to 5 more options and it's quite large obviously....(L. 55-58).

Good hospitality was a value that overrides being healthy and so cannot be used to predict behaviour through a calculation of the costs and benefits to an individual, as this was often not relevant to the social unit. Instead, culture, tradition, habit and respect for guests' preferences were common considerations in choosing meals whilst health and ease were occasional considerations. Equally, Radley (1994, p.194) argues, 'people conduct their lives – including those things thought to be 'healthy' and 'unhealthy' – according to beliefs that involve a range of other concerns apart from health alone'.

Naresh: Well at me Nan's house... I think she believes a curry is only nice if you have oil in it so you do see the oil floating a lot (L. 232-235).

Social factors seldom make it easier to eat healthy foods but rather make it more difficult to make healthy choices (Hargreaves, Schlundt & Buchowski, 2002) and this strong hospitality culture was a pivotal social norm. Therefore mother's intentions to control their children's dietary intake, is often hampered by adhering to cultural norms that would be harmful to health (for instance, eating deep fried appetisers out of respect for host). Mothers, if they tried to discourage overeating would receive opposing comments from family members. Within the UK South Asian community perceived barriers to change far outweighed perceived benefits of health behaviours and where the behaviour was linked with emotional and social aspects, difficulties were perceived greater than any long term benefits (Lucas et al., 2013).

Khatira: I think that there is lots of lovely food around you and that is a main part of the culture and honestly they are delicious I can't blame my children because even I as an adult feel like (laughter) yeah it's difficult for me to control it (L. 116-119).

It was common for the whole family to overeat in this pattern of and important moral conflicts arose between individualist and collectivist goals as mothers felt frustrated at not being able to go against cultural norms. For example, the frustration at the individual goal of healthy eating compared with the shame to the family of not providing guests with generous 'special menu' food. Although one mother due to her diabetes diagnosis now went against the grain to provide guests with fruit rather than the appetisers (samosas and biscuits) she normally provided.

Ameena: Yes that's why (diabetes) it has changed otherwise we wouldn't be changed we would still be having all the samosas, rolls and oily stuff....when she (her mother) comes to my house there will be fruit but when I go to my mums house she gives me samosas (laughter) (L. 360-365)

Grandparents were seen to provide children with unrestricted access to food in particular unhealthy snack foods. This frustrated mothers as they were trying to teach their children control whilst the Grandparents voiced concern over children not eating enough and being too thin. Mothers concluded that they did not understand what children should eat to be healthy. In UK South Asians Pallan, Parry, and Adab (2012) recently found there is much concern around children being underweight, especially among older community members, and hierarchical family structures result in grandparents exerting control over children's lifestyle behaviours.

Belour: All my daughter has to say is 'Bibi I want this' and she will be like ok. (L. 387-388)

Naresh: It is really difficult with 70 year old and 80 year olds and you telling your children no you can't have a chocolate and a packet of crisps and a cake....sometimes I'd actually say and sometimes I offend them....it's one or another if they are having an ice cream then they don't need to have a bar of chocolate at the same time so I think he (grandparent) is getting more used to it (L. 236-244).

Selective code - Leisure time

Cultural factors played a limiting role on how leisure time was used with decisions mothers making about their children's health related activities being validated by the complex cultural and moral environment in which they lived. After-school and weekend activity, whilst viewed beneficial is not often possible due to practical, social and structural barriers. Firstly, religion influenced preferences for and opportunities to engage in physical activity due to the majority of children attending the mosque daily after school. Also including lack of time or money, difficulties with childcare, large family and extended family commitments, safety fears, no one from the community attending and sometimes children were being oppositional to the activity.

Naresh: South Asian children within this area, if they follow the faith of Islam go to evening classes at mosque...my son has after school clubs at school and he can't actually access them because they run till 4.45pm whilst his evening classes start at half four so he can't access them and that's fair enough (L. 456-462).

Children were viewed as being active as a result of 'being children' and due to their attendance at school, which provided informal (playtime) and formal (physical education lessons) physical activity reducing mother's concern. Few children walked to and from school even though they lived close to the school. The concept of being active day to day is important however incidental activity was difficult to fit into daily routines because travel by car was viewed essential to manage their busy schedule, even for short journeys. A recent study (Owen et al., 2012) in urban multi-ethnic children in the UK found South Asian children were the ethnic group most likely to travel by car despite living within closer proximity to school and spent less time in moderate to vigorous physical activity.

Khatira: Sometimes when my car is in the workshop or garage, oh my god it is a very big thing for her (daughter) that she is walking to school and that's not nice to really look at your child being very sad in the morning because the car is not there (L. 214-218)

Preferences and activities that were culturally acceptable appeared important within this group. Spending time as a family is valued and prioritised over individual pursuits thus meaning the social value of an activity needed to be family or peer centred. Motivation was greater for shared joint goals rather than the western focus of individual goal based motivation. This may be why South Asian groups generally participate in a more restricted range of sporting and leisure activities than white Europeans (Hayes et al., 2002). Weekends are family focused and frequent social occasions at weekends by their nature did not involve much activity.

Although mothers expressed motivations to be active for reasons related to their general health and wellbeing such as feeling good, sleeping well and reducing weight around the waist. Mothers, compared to their children and spouses, felt it was especially difficult for them to fit physical activity into their routines. Mothers preferred group exercise as this supported their motivation to attend. Likewise,

Sriskantharajah and Kai (2006) suggest that the promotion of exercise with socially enjoyable outcomes would encourage participation among South Asian women. Lack of culturally appropriate activity is often cited as the cause of low physical activity in South Asians but all mothers felt local opportunities for single sex activity sessions were readily available, although at times this was an issue.

Naresh: Men I guess (laughter) it is a restriction I mean I go badminton and it is a mixed hall which is fine but I do cover but sometimes it is a bit difficult when you are running around with these long flowy garments on so it is a bit difficult running around so sometimes to have female only gym days (L. 446-451).

At weekends and social events 'letting go' was an outlook cultivated and reflected in the comments mothers made that 'a little of what you fancy does you good', and too healthy a lifestyle was 'unhealthy, not to mention unnatural'. These beliefs reduced their motivation to resist temptation and encouraged behaviours related to relaxing, spoiling and release. Weekends were organised around hospitable family occasions, which involved 'letting go' and there was often a distinct difference in dietary intake on weekdays and weekends. Self-control and discipline were valued on weekdays with a more focused pursuit of eating healthily during the week to counter the excess of weekends. Weekdays were bound by time and schedules and it was easier to control the types and amounts of food eaten by the family.

Khatira: Sure in terms of control I am not that content that I have that much control if I have control it's mainly five days of the week Monday till Friday but after Friday weekends are out of control and the reason is because somebody's coming or we are going out (L. 33-37).

Farida: My mum knows we are coming so she will go and buy all those cakes and stuff... we do have it at night it's when I make hot chocolate and there will be cakes and stuff (L. 183-186)

An important value attached to 'letting go' was unrestrained eating by the whole family. Reflection on food choices shed light on processes involved in mother's decision-making. Whilst mothers were aware this was unhealthy it was expected and enjoyed.

Belour: My aunt will say let him have it he's thin and I will be like it's not for the thinness (L. 280-281). With an Asian mentality unless they are fat they are not healthy and my children always had someone next to them one cousin or another who was always bigger and I was always constantly told that I had to feed them (L. 430-433).

Mothers believed 'treat' foods were important for children and being too strict has the undesired effect of drawing attention to them and increasing children's desire for them. Also, that restriction may encourage eating disorders as children become self-conscious. Research similarly has shown children can become overexcited when restricted foods are available, so that self-control is not exercised and eating becomes frenzied (Ritchie, Welk, Styne, Gerstein, & Crawford, 2005).

Khatira: If its once a week or at the weekends they can't enjoy it as much as their cousins do because they are already chubby and on top of that the pressure and they say 'so and so had two or three doughnuts' and they say 'why not me' and they cannot understand (L. 788-793).

4.2.2 Conceptual category: Health beliefs

The Health beliefs mothers held influenced the strategies they used to establish a healthy lifestyles, their pursuit for information and their focus on moving away from tradition. There was general awareness of key dietary messages and an emphasis on dietary variety and balance. However, aspects of their lifestyle created barriers to fulfilling their intentions to be healthy. In general, while there is a burgeoning literature on health beliefs, what is less clear is the impact of food beliefs and habits directly on food choice. The importance of understanding cultural context in food choice is brought out in health behaviours mothers viewed important and these beliefs may differ from the mainstream. For example, the significance of home-cooked meals and the role of fast food as part of weekly routines.

Selective code: Key components of a healthy lifestyle

Mothers held common beliefs about factors involved in establishing a healthy lifestyle and this focused primarily on the family's dietary habits. Their motivation was internally driven by the belief they were responsible for their children's diets whilst spouses were not implicated in this role.

Radhika: They (her children) are young they are not aware of what's right and wrong. The 14yroid might know a bit more than the other younger ones but I do promote and try and introduce lots of fruits and things obviously at the end of the day you know say to them look have you had your fruits you have supposed to have had, talking to them really (L. 86-92).

Within their own home mother's felt confident their family's diet was healthy as they were in control being the chief purchaser, provider and preparer of food. Mothers engaged specific actions and behaviours to enable them to adhere to what they believed were important health messages. Though mothers lacked technical knowledge, their lay explanations of freshness, not overindulging and moving away from tradition guided their approach to a healthy diet. Whilst intent to provide a healthy lifestyle for their family was certainly high, good intentions were invariably insufficient to result in the health behaviours mothers desired for their family. One such factor was mothers not feeling able to control their children's fussy eating behaviour. This included behaviours such as strong likes and dislikes, consuming a limited number of food items and refusal to eat vegetables and/or foods from a variety of food groups.

Naresh: I tried to give my daughter broccoli the other day at school she says she eats it but at home she refuses too so with vegetables it's a bit difficult in our family (L. 281-284).

Radhika: he is really fussy and he has always been a fussy eater since he was a baby obviously because he gets all the dizzy spells and you know sometimes he gets really lethargic and tired and I think it's just because he doesn't eat enough. And he is really, he is really slim in his class and all the other children are big built and I think it's just one of those things one of those children that just doesn't like eating I worry about him (L. 176-183).

A lack of knowledge about how to deal with fussy eaters led to concern as mothers worried over children not receiving adequate nutrition. This concern prompted mothers to make compromises with their children to ensure they ate enough food. This compromise usually involved less healthy foods.

Ameena: Now I am worried about my eight year old child he is overweight and he doesn't like vegetable and the only thing I stop him from having is eating chicken by giving him like noodles if I give him noodles then he wouldn't go for meat so like vegetables or plain noodles....I think that's helping him a lot because he wants meat and chicken all the time. (L. 207-215)

Belour: Well they have packed lunches they have a bit of fruit, some croissant, a sandwich but they are like very fussy they will only have a butter sandwich they won't have lettuce or tomato in it or cheese sometimes and salami. (L.559-562)

Most mothers believed children grow out of fussy eating with age and viewed children disliking vegetables as normal and expected. However, it still caused concern for mothers and sometimes they blamed themselves for increasing their child's fussiness by pandering to their likes and dislikes.

Farida: I used to cook two different things in case they don't like one thing then at least they will definitely like the other but since the last three years I have realised if they do that all my life they will always have that fussiness in them (L. 154-158).

Ameena: When I get the burger I want them to have some salad with it but they don't like salad.(L. 235-236)

As Hendy and Raudenbush(2000) found children are less likely to be of a healthy weight and follow a healthy diet if there is negative snack modelling, allowing many food choices and preparing special meals (differently from the family meal). This child led approach to parenting has also been shown to be more likely to result in children's diets being high in 'children's foods', which, in the UK at least, are foods considered 'junk' or highly processed (James, 2008).

Eating daily home cooked meals using fresh ingredients is seen as a key component to a healthy lifestyle. It is an ideal eating practice as food choices of children can be monitored and healthy choices facilitated, leaving mothers feeling more in control of their children's diet. Mothers were proud of providing home cooked meals as studies have found women from minority ethnic groups value 'freshness' as opposed to prepared or pre-cooked foods (McKeigue & Sevak, 1994, Wyke & Landman, 1997) and understanding nutritional labels was therefore not important.

Belour: Erm the sugar and the fat not the calories so much the fat and sugar but we usually don't buy things like that only yoghurt and cos vegetables don't have labels and we don't buy ready cooked meals just cereals which they all eat and breads and things like that but we cook everything. (L. 597-601)

Sabah: I cook homemade food, which is much healthier, and I don't really like red meat and once a week we grab take out or eat out but everyday its fresh cook (L. 112-115).

Breakfast was prioritised for a healthy lifestyle, although the importance was placed on eating adequate amounts of food and drink rather than the nutritional value of the food. High sugar breakfast cereals were popular amongst children and whilst mothers wished their children's breakfast were healthier, they felt it acceptable that children want and need something sweet for breakfast.

Belour: I don't know how you tell but I am sure the ones that they like aren't very healthy like it's all coco pops and cheerios and honey nut cheerios and crunchy nut those are the ones that they like they have gotten into crunchy nut the past few days so they are eating that (laughter) (L. 606-610).

Ameena: My children in the morning love to have cereal and I want them to have other things like brown bread but they don't really like it they just want to have their cereal and their favourite oneI am very disappointed unfortunately only rice crispies are not that bad to compare with others but yeah.

Farida: My children love coco pops and frosties so I won't buy it every shopping because once they finish that box I don't go and rush to look for it (L. 63-65).

Western style fast food was enjoyed on a weekly basis due its convenience, availability, low cost, mothers 'needing a night off' and their children's enjoyment. Various studies note the adoption of the fast food part of the British diet among South Asian migrants (Landman & Cruickshank, 2001, Simmons & Williams, 1997)

Ameena: I will give him chips or wings or burger only once a week (L.246-247) Nowadays you can get takeaways so easily so it's like when I am feeling lazy I just say get some chips (L.277-279)

Naresh: Once in a while we will have a take away but its once a week....I know if I fed my son a quarter pounder everyday he would be happy having a quarter pounder everyday if I fed my daughter chips everyday she would be happy with that so I want them to be able to see we have a cooked meal every day (L. 275-380).

Mothers viewed this type of food as a treat but felt confident they felt limited it sufficiently. Mothers did not clearly describe any negatives about fast food for example that they tend to be high in fat and salt, low in fibre, fruit and vegetables, (Public Health England, 2013) more energy dense and have a higher fat content than meals prepared at home (Prentice & Jebb 2003). Although due to the proliferation of outlets around their home and schools there was a sense of inevitability of them eating fast food particularly as children grow older and have pocket money to spend.

Selective code: Seeking or receiving guidance

Parental readiness to make lifestyle changes was often prompted by family and professionals. Guidance about how to lead a healthy lifestyle was sometimes sought out or given unsolicited to parents. Either way advice received could be confusing or contradictory. Mothers were especially aware of dietary messages for adults around reducing risks for high blood pressure and cholesterol with the focus on dietary change i.e. eating less red meat, butter, cheese and eggs rather than a combination of diet and physical activity. High prevalence of family members with these health issues increased significance of these health messages and prompted mothers to

purchase low fat foods, use healthier cooking oils and encourage their family members to do the same. There is evidence changes in food selection and nutrient intake among South Asian mothers is consistent with current dietary recommendations for health (Anderson & Lean, 1995).

Rhadika: I kept saying to him (husband) you need to work your way around it even with breakfast having a fried breakfast with eggs and like that wasn't good for him and now I just say have a bowl of cereal you know (L. 202-206).

Farida: Drinking milk I buy the full fat milk and the semi-skimmed milk but I am now trying to get my kids to drink semi-skimmed in their cereal or glasses or milk (L. 79-81).

Belour: It's the other way round it's the younger ones telling the older ones to monitor what you are eating.... (L. 637-639)

Healthy lifestyle advice was received from health professionals and mothers were pleased when they received professional advice. Although advice was not always easy to obtain as appointments were not at convenient times or locations.

Khatira: Ok the other thing is why there are not dieticians employed with the GPs because they are at the hospital....it's really difficult to take time out and make an appointment on top of a busy schedule and you think why bother (L. 651-656)

Mothers found dietary change to well-established dietary habits were more difficult to implement because they were not convinced about the benefits of the proposed changes. Some immigrant or low income groups have been found to have difficulties to understand and make use of health information in ways to promote and maintain good health (Kreps & Sparks, 2008). Face to face advice was preferred to advice from the Internet, which was considered time consuming and contradictory. Also, word of mouth was preferred to receiving leaflets and written information as they admitted this was unlikely to be read due to lack of time and inclination. The display of traffic light nutritional guidance was also a form of guidance which mothers and children both used.

Naresh: I won't sit on google and google search for hours and hours I believe what a doctor will tell me what a nurse will tell me (L. 188-190).

Khatira: They are straight forward because they are telling you that a packet of crisps how much it's how much calories it has and even the burgers and macdonalds they tell you and even my children and one my daughter she was telling me mum look at this and then we noticed and before we didn't used to look at the calories (L. 434-439).

Health messages were received from 'health conscious' family members and sometimes those who had received dietary advice from professionals passed on messages. This is the likely reason for mothers being confident on specific dietary messages for adults to reduce risk of high cholesterol and blood pressure. There is evidence word of mouth is the primary source for delivery and receipt of health-related information within South Asian groups (Farooqi, Nagra, Edgar & Khunti, 2000, Lawton et al., 2008). The prevalence of lifestyle related disease amongst family members had led to more regular conversations about healthy lifestyle choices viewed as useful but also led to confusion about the links between health, lifestyle and the nature of hereditary disease.

Radhika: My sisters and brothers all encourage each other that you have really got to look after your diet and lose your weight because of dad (dad has diabetes) and that (L. 245-247).

Khatira: I said we are using the olive oil and they (dietician) said you still have to be careful and I don't know I was thinking digestive biscuits were good and they said please stop it (L. 415-418).

The introduction of school rules regarding the content of children's packed lunches was viewed positively by mothers as it reduced their control over what went in the lunchbox. Rules forced them to make healthier choices making it easier for mothers as children could no longer pester for unhealthy food or drink in their lunchbox. Guidance received from schools about healthy lunchbox options was helpful and encouraged mothers to steer away from previous ingrained habits. However, once children were at secondary school they chose their own food and mothers suspected they did not choose healthy foods but were resigned to no longer having any control.

Sabah: The packed lunch is no chocolate or crisps or that, schools don't really allow it anymore before I think it was ok but now they don't so if it's anything that's not healthy they do ring you up and talk about it which is good so she takes a yoghurt and cheese strings (L. 66-71)

Selective code - Moving away from tradition

The act of moving away from traditional South Asian cooking reassured mothers that they were providing their family with a healthy diet. This was because moving away from tradition meant not engaging in what was seen as the risky (unhealthy) traditional South Asian diet. Likewise, Greenhalgh et al., (1998), and Lawton et al., (2008) found amongst South Asians with type 2 diabetes, traditional food was viewed as a risky option. Although traditional cooking was still valued when receiving guests and for special occasions, mothers chose to take on different dietary choices to their own parents.

Farida: I am sure you are aware of the Indian diet it is not exactly healthy but we don't really follow the Indian diet so it's ok (L. 20-22).

Naresh: I know all that Asian diets can be pretty bad I have cut down on things like oil I have never used a lot of oil and I have never used a lot of oil, salt, sugar or any of that in my cooking (L. 223-236).

Moving away from tradition inherently involved dietary acculturation, which was evident as mothers, unlike their parents, regularly included foods from different cultures Italian (pasta), Asian cuisines (stir-fry) alongside fast foods. Dietary acculturation occurs at a community and individual level from exposure to a new culture where individuals, to varying degrees, adopt the dietary and lifestyle patterns as well as the socio-cultural practices of the indigenous population (Shetty, 2002). All mothers described moving away from traditional cooking, recipes and ingredients as a way of providing healthier meals for their families. Traditional recipes were also adapted with the reduction, removal or swapping of ingredients. There was a heightened awareness among mothers that an Asian diet was unhealthy because of the amount of salt, sugar and oil used in cooking, frying of foods, use of red or fatty meats, high sugar sweets and desserts.

Sabah: Our Asian food it's not something that bad but because we use a lot of butter, ghee and all that stuff it does become more fattening food (L. 150-153).

Ameena: If you are Asian we like more oily stuff, sugary stuff, and salty stuff these are our favourite but now it's like life has to be changed but we have to eat something. (L.167-168)

Belour: No (laughs) it's (traditional food) not very healthy but is home cooked I mean before it depends where you go there is a lot of oil in it but we cut down on the oil as much as possible put the bare minimum. (L. 127-130)

The traditional consumption of heavy breakfasts or brunches had been described as changing to lighter, healthier options. Traditional breakfasts had included fried savoury foods, fried rice and meat or English style fried breakfasts. If these were still consumed it was normally at the weekend.

Ameena: nowadays I will choose the light food instead of giving them chapattis in the breakfast time (L.770-772). I used to make different rices, fried rice in the morning I wouldn't do that now it's so much change (since being diagnosed with diabetes) I don't believe myself I did that(L. 784-786).

Naresh: I don't actually do fry ups and things like that for lunch (anymore) (L. 25-26).

Sabah: At weekends we go for a nice breakfasts....we have a late breakfast omelettes and he (husband) sometimes goes for sausage and scrambling and like that he doesn't like anything fried he like everything grilled and in the oven we avoid frying stuff (L. 288-233).

Snacking took an important role in households and was viewed as a custom, not traditional to South Asian culture but influenced by British customs, particularly because of the ease and accessibility of these goods, minimal preparation and children desiring these foods. Kumar et al., (2004) found the inclusion of these snack foods leads to ethnic populations having higher levels of fat, salt, and sugar in their diet and mothers found it difficult to monitor and regulate their children's intake

appropriately, particularly as children could buy unhealthy snack foods easily themselves.

Ameena (2nd gen.): I don't get no crisp box like I used to get big box and they used to have one, two, three a day nowadays it's stopped.....(L.259-260).

When we (when Ameena was a child) came home from school the snack was a bar of chocolate and a crisp, so I am trying to follow my dad's footsteps but I can't there is a shop on the corner they just run and get it...(L.275-279).

Belour: I prefer western snacks like crisps and chocolate cake and flapjack and that type of stuff (L.177-178).

4.2.3 Conceptual category: Barriers

Various misperceptions and constraints acted as barriers to a healthy lifestyle with Mothers feeling they had little control in some situations. They lacked motivation and confidence to negotiate these barriers.

Selective code - Misperceptions

Mothers were unaware that South Asians are a high risk group for certain lifestyle-related diseases and were unaware that the prevalence of heart disease and diabetes is disproportionately high in UK South Asians (Whincup et al., 2012). Recognition by mothers that they had high rates of lifestyle related disease within theirs and/or their spouse's family made mothers wonder why this was and whether this put them or their husbands at risk.

Farida: My mother-in-law she has diabetes and she has had a few health problems and erm I am worried in that sense as I have hear it can be genetic erm hereditary and erm you know it can be passed down sort of thing but I am hoping that doesn't happen (L. 263-268).

Naresh: My father has very high blood pressure and high cholesterol, my mum has high cholesterol but I think she is borderline diabetic now, my grandparents have diabetes. My uncles, my mum's two brothers have diabetes we have got so much of that in our family... (L. 90-96). So I think it is a lot more paramount in the Asian community but then I haven't researched it to say it is not happening in other communities so... (L. 164-167).

This puts them at a disadvantage particularly as there is a drive for individuals to take greater responsibility for their own health, yet they are being guided by health messages aimed at the majority white population. Stone, Pound, Pancholi, Farooqi & Khunti (2005) found reference to family networks and history of diabetes among family or friends creates the main informational sources, which appears to reduce the need to seek additional support. Aspects of lifestyle that increase risk of disease have been found to lack clarity in the UK south Asian population (Darr, Astin and Atkin, 2008 and Farooqi et al., 2000). The need to educate South Asian communities was highlighted recently when the South Asian Health Foundation (SAHF, 2012) conducted a series of education sessions targeted at people in this community and many were unknowingly at high risk of developing type 2 diabetes. When mothers reflected on motivations to lead a healthy family lifestyle they felt if they knew more about their risk they might be more motivated to engage in health behaviours.

Belour: I wouldn't say that I know other than having too many sweet things but other than that I wouldn't know (L. 474-475). I would like to know what type of things contribute to getting type 2 and how likely it is having it in the family... what things you can actually do to prevent it and what you should be concentrating on eating and things you should not eat (L. 499-504).

Ameena: We talk about healthy food at home.....my daughter went dietingI said no you shouldn't do that you are young like my mum used to say to me 'you are young you should take more food'but now my mum's weight is not that right so I would say when they said 'I don't want dinner' I would be really angry and say 'you have to have dinner' and I used to force them to eat now I wouldn't (L. 692-706).

Sabah: Yeah I mean years ago I used to think it (diabetes) was because you have a lot of sweet stuff but they say it's nothing to do with that erm sometimes well that like why I had that wrong understanding but overall what causes the diabetic is it in your blood or something? (Asking the interviewer) (L.334-338).

Those with diabetes for example rarely talked about their condition and one mother recently diagnosed with diabetes explained how although her mother and aunties all had diabetes she had previously known little about the disease and was shocked when she herself was diagnosed at a much younger age. Lawton et al., (2006) found for some UK South Asians the perception of ill health being due to age rather than lifestyle was borne out of their exposure to the high number of family and fellow community members suffering from numerous health problems.

Belour: She (her sister-in-law who does not have diabetes) is telling all of us that we should be aware of what you eat and that it's in our future pretty much so you should try and prevent it from happening (L.634-637). No it's not really talked about (by those with diabetes) it's like they know they have it they know they should monitor it none of them do but they convince themselves they have (L.657-659).

When appraising a healthy weight mothers did not always view their child's weight as a good indicator of health. Weight gain in children was not directly associated to diet or a child's level of physical activity though both are major environmental factors in the aetiology of childhood overweight and obesity (Birch & Fisher, 1998). Contrary to this when mother's considered their own weight gain they associated it largely to their lack of physical activity. Mothers applied their knowledge of the weight trajectory of their child's siblings, cousins, parents, aunties and uncles to explain their child's size and shape. For example, if their child was chubby like their older sibling was at their age but the sibling had grown slimmer, they were reassured this would happen to the younger one. Also, if their husband was of big build they expected their son to be big build. Weight and shape were viewed as externally controlled (born big or genetics) rather than internally (dietary choices, physical activity behaviours).

Khatira: Unfortunately my children has always been chubby I had very big children from the time they were born (L.230-231).

Ameena: I don't worry because the older one was skinny always skinny my daughter was always chubby and she is still chubby and the third one was chubby then went tall so he is medium and this one I am showing them that look all these three you are going to stick with one of them either you grow tall or either you going to be chubby or are they going to be skinny you don't know (L. 1091-1097).

Concern of rapid weight gain or chubbiness in a child was minimised by the view that puberty helped a child's weight 'even out' or 'balance out' and for them to grow out of their 'puppy fat' a finding consistent with previous research (Carnell & Wardle, 2005). Also, suggesting that being overweight is viewed as a temporary issue, whereas there is substantial evidence indicating that obesity in childhood tracks into adulthood (Singh et al., 2008). Where a child might currently be described chubby mothers viewed them as likely to grow up 'physically strong'. This is consistent with previous studies, where parents used positive adjectives such as 'big-boned' to describe their child's weight (Park et al., 2013). This suggests that overweight is either not viewed negatively or as a cause for concern, or that parents acknowledge that their child is 'large' but do not perceive them to be 'overweight'. Therefore the standard practice of measuring children with Body Mass Index is unlikely to influence mother's views of their child's health or motivate behaviour change. Being overweight was perceived more of a concern and problem for older children who may be teased.

Belour: My younger daughter is only 5 but she has got she is a bit more podgy then my son but I don't know with some things I just think they are like they kinda fizzle out and she will be an ok weight (L. 422-425).

Sabah: I think she has put on quite a bit of weight but she is growing now she is turning 12 so I think that she will drop down a bit on her weight she has not gone fat but a bit more chubby on the hips... yeah a bit at the moment but I think it is because she is turning 12 becoming like a young lady so that's what I think once her period starts she will go down in weight (L. 295-304).

Farida: My ten year old she is not fat or chubby but I think she might be heavy boned as well but I am not sure because she is a bit taller my twelve year old is actually short skinny and petite so she kind of looks giantish compared to the twelve year old and I have people telling her about her weight and stuff and I think because she is compared to that people think she is fat so she is not fat (L. 423-427).

Various factors were not identified by mothers as influencing future risk of lifestyle related disease such as ethnicity, overweight, and inactivity. Mothers focused instead on family genes, dietary behaviours and increasing age as determining risk.

Radhika: Well ideally its concern for myself and my husband because his mum has got diabetes as well so it runs in his family and like they say if it runs in the family it could be that your children could get it so concern for myself but I mean in the long run concern for my children because if I have got it in case I pass it on to them sort of thing really in the long run so I am worried for myself as well and husband (L.111-117).

Within mother's narrative around feeding children their concern focused on children not eating enough, not finishing their meals or eating to schedule rather than the nutritional value of food consumed. Recent studies of South Asian families show they exhibit specific challenges including display of maternal affection through overfeeding (Misra et al., 2008).

Ameena: It was so bad to say no, he wanted a chocolate bar and a crisp a day so I am giving him that to stop him craving for more crisp everyday Before, shopping like cakes, sugary stuff like croissants, donuts and stuff but nowadays I get more crumpets, crackers...

Selective code - Constraints

Lack of time was viewed as a key reason for lack of physical activity by mothers. Mothers felt they did not have time to look after themselves and so were not being as active as they wanted to be. Lack of time meant that having a routine or pattern of weekly exercise was difficult to sustain. Time was prioritised around the family and

this dictated how time was spent. Also, having a large extended family living nearby meant that free time was often scarce as familial commitments took priority.

Naresh: I am a driver...I am in such a rush all the time to drop the kids off at school then go home and then rush from work to pick them up and go home (L. 320-323)...and because I have grandparents and they are all local and because he is 86 going on 87 not very well at all at the moment I have to make a lot of time and I am constantly on the go and the only exercise I get is going in and out of my car (L. 327-331).

The use of the car was a key part of being able to manage their time even though many places were within walking distance. With juggling family and work commitments it was difficult to find time, childcare and motivation. Similarly, a report suggested that the main barriers among black and minority ethnic groups (including South Asian) to meeting recommended physical activity levels were practical constraints such as lack of time, working hours and home responsibilities (Health Education Authority, 1999). Some mothers had managed to fit in regular or occasional activity into their schedule as they recognised their lack of physical activity was not always due to lack of time but motivation. Spouses had more opportunity to be active, as they did not have the same childcare and domestic commitments of mothers and mothers viewed themselves as the main caregiver for their children.

Sabah: Well work and home life really you go home and you have kids, cooking it's never ending. If I had like spare time I would spend more time in the gym and more active stuff (L.276-278).

The data captured some of the wider societal influences on behaviour in addition to family and local community influences such as safe places for children to play and safe street so families can walk and cycle more. Issues relating to families' wider neighbourhoods (e.g. fast food outlets; lack of safety) illustrated parental concerns that environments could thwart intentions for healthy eating and activity. Behaviour around food choice tends to be habitual in nature and by definition outside our awareness, thereby making it almost impossible to control (Rothman, Sheeran &

Wood, 2009). Habitual behaviour is more dependent on our environment than conscious control so the proximity and density of fast food outlets may have more influence than mothers being aware that fast food is not healthy. While there is little research linking food access with obesity as an outcome measure (White, 2007), understanding the relationship between what we eat and the environmental context in which these food choices are made is essential to the development of long term obesity prevention strategies (Holsten, 2009). Also, children were restricted in their activity due to the lack of outdoor space and rules and regulations on housing estates.

Ameena: Erm especially in London a polluted area you need some green but actually nowadays the council has provided these trees in every road that is easier for us but before it used to be flats and just concrete and it's not that much energy and oxygen to go with it and I never used to like going out but because of the trees I like going out (L. 565-570).

Naresh: The children aren't allowed to play balls there or anything apart from the bikes and with their bikes they have to be careful because the older generation do not like the children on the bikes (L. 483-487).

4.3 Advancing the theory

The goal of a grounded theory study is to generate a theory that accounts for a pattern of behaviour relevant to those involved (Backman & Kyngas, 1999). Throughout this study, the aim was to 'write about concepts, not people' (Glaser, 1978, p.134) and out of the analysis of the data, three final categories emerged; *cultural identity*, *health beliefs* and *barriers*. These categories and their properties, tell the story of the influences and pressures on South Asian mothers and the balancing act they engaged in as they negotiated a healthy family lifestyle.

Identification of a core category is central for the integration of other categories into a conceptual framework or theory grounded in the data. This core category determines and defines the theoretical framework and is the category that organises all the other categories by resolving concerns (Glaser, 2002). For some time, *compromising* and *negotiating* as processes seemed close to resolving the many

categories as core categories. However, they did not capture the discord that the mothers interviewed described, and the ways in which their motivation and confidence to seek healthy behaviours altered by situation and influence. The complexity of the environments within which mothers were making these decisions was not clarified by just the process of *compromising* and *negotiating*. Knowing Glaser's judgment (1978) not to settle for a category that leaves other codes or categories out, further analysis needed to take place for me to find a higher concept. In doing so, I endeavoured to avoid what Wilson and Hutchinson (1996) describe as mistakes that novices make in using grounded theory, such as lacking flexibility, looking for premature closure rather than analysing the data fully, and not moving to conceptual and theoretical codes. I noticed there was a shift as my research impressions gave way to an understanding of processes that took place over time, and therefore took on the descriptions of 'events' or 'incidents' as grounded theory requires. At this stage it became clearer to me that there were actually important social processes to be discovered in the data, which aided disengagement from the data and provided me with an opportunity to look down on the patterns. The process of finding a category that transcended all the categories was challenging, but by constant comparative analysis of the data one social process began to emerge to form the theory. At this point it was helpful to consider the questions Charmaz (2006) suggests a researcher should; 'So what is the problem that my participants see?' and 'How do they believe they address/resolve the problem they face?' This helped me to find the basic social process that emerged in the data common to all mothers, which underpinned all the other processes. I used diagrams to facilitate the emerging conceptual categories included in the different factors and situations impacting on mother's use of compromise and negotiation. The data gathered shows descriptions of negotiations between various influencers and situations often relating to diet, pleasure and health seeking behaviour and social outcomes. Re-reading of interviews helped me identify the way in which, implicitly rather than explicitly, all the mothers expressed concern relating to their perceived lack of control in situations driven by the central phenomena identified and their need to engage in a balancing act to negotiate a healthy family lifestyle. It is this degree of saturation in both breadth and depth, which led to its selection. The basic social process identified was the *balancing act* that mothers were constantly engaged in.

An explanatory model was then developed to embody the concepts emerging from the interviews and is suited because it is dynamic, and can change based on the situation. It developed from a figurative diagram (see *diagram 1*) of concepts being considered a more valid approach to explain the central phenomena influencing the balancing act South Asian mothers engaged with to negotiate a healthy family lifestyle.

4.3.1 Core category: Balancing act

Exploration of mother's perceptions of health behaviours for a healthy lifestyle, provide understanding of the particular contextual influences operating within UK South Asian communities. Investigation of these offers insight into factors that may be mediators of motivation to change behaviour influenced by *cultural identity*, *health beliefs* and *barriers*. For instance, decisions mothers made about theirs and their child's health related activities were influenced and validated by the complex cultural and moral environment in which they lived (i.e. children attending classes at the mosque after school activity removing opportunity for physical activity). Within these decisions mothers engaged in various styles of negotiation to balance the pressures and influences on themselves and their family.

Firstly, mothers regarded adhering to the social norms of pleasure seeking behaviour at weekends and social occasions as a rather strong motive for action and implying little control was possible over their own and their children's behaviour during these times. Some descriptions falling into this category presented unhealthy habits that had at some point been removed from daily routines but returned to during these times i.e. consumption of deep fried appetisers or cream cakes. Likewise descriptions of lapses were found in particular of holidays, special religious events and visits with friends or relatives. These special occasions were presented as exceptions of everyday routines that required letting go of the normally restricted, health seeking diet. Here too, letting go was presented as essential as during special occasions one simply must indulge and enjoy, otherwise one would be too rigid a parent and strict health enthusiast. As Williams' (1998) argues lay concepts

of health are complex and ambiguous and that, in opposition to the moral pursuit of health and the attempt to comply with recommendations to reduce the riskiness of (health) behaviours, lay concepts of health often involve the notion of pleasurable release and throwing all caution to the wind. The regularity of these times of letting go was mostly at weekends, which created a balance of health seeking behaviours during the week and pleasure seeking and social outcome focused behaviours at weekends.

The second balancing act was recognised in descriptions of acceptable insignificant pleasure producing habits regarded as not ideally healthy. Noticeably in these accounts i.e. the consumption of treats such as fast food and sweets, mothers emphasised that these habits do not portray their family's overall lifestyle.

Consequently, these habits do not threaten their health and are not presented as indulgence or letting go. Likewise, people make food choices within the context of the social, economic and cultural environment in which they live. As physiological needs are met, personal preference becomes a major determinant of food choice along with religion, other cultural factors and convenience, price and nutritional value (Nestle, 2002). Here, mothers presented themselves and their children as finding the right balance of indulging in a conscious but controlled manner regulated by the mothers. Instead of abstinence, mothers considered that unhealthy treats may be consumed, but in moderation or in disciplined and limited amounts, thus relieving them of some responsibility. Although moderation was often not as successful as implied mother's downplayed their responsibility, and proposed they should not be judged too harshly as these are common 'vices' within British culture rather than Asian culture.

The third pattern is the family's desire for something sweet despite the minimisation of the availability of sweet, unhealthy snacks and treats in their home environment, and the family's consequent victory over the initial craving by swapping or modifying the craved treat with less unhealthy products. Minimisation is a type of deception (Guerrero, Anderson & Afifi, 2007) involving denial coupled with rationalisation in situations where complete denial is implausible. Minimisation is one of the most common ways we reduce our feelings of guilt (Hoyk & Hersey, 2008, p.68,). As in the previous category, here too, letting go was balanced by being presented as

happening only occasionally and a moment of pleasure is given only a small niche in the centre of a principally health seeking lifestyle. In Grahams' (1984, p.187) discussion of health in families it is pointed out 'health choices are more accurately seen as health compromises, which, repeated day after day, become the routines which keep the family going' and suggests it is more realistic to speak of health compromises, in that the consumption of food is influenced by the socially structured context in which people live out their lives. Compromises were regularly made by mothers, however, even though these compromises were built from their health seeking intentions they did not always work as compromising often did not reduce unhealthy behaviours. For example, allowing children to have a bag of crisps if they ate a piece of fruit or keeping whole milk in their milkshake if they had semi-skimmed milk with their cereal. Mothers found balance by creating compromise rather than removing foods. Likewise, Weinstein (1987) reported that individuals ignore their own risk increasing behaviours and focus on their risk reducing behaviours. Mothers chose to balance unhealthy foods (pleasurable foods) with healthy foods. As the majority of positive consequences of eating pleasurable food are in the present and the majority of their negative outcomes in the future, this outlook allowed mothers to disregard the need for concern at this time.

In respect of food the fourth pattern of negotiation was made up of descriptions where the pleasure value of a healthy product was set as high as or even higher than that of an unhealthy product. This type of description was the least often used by mothers however, in the descriptions of pleasurable food, mothers conveyed their families liking of sweet foods and indulgent hospitality meals but also their enjoyment of healthy foods such as tropical fruits, yoghurt or nuts as satisfying and valued foods. Although 'healthy foods' were also viewed as needing to be eaten in moderation due to their perceived high sugar or fat content. Therefore even healthy foods needed to be eaten in a balanced manner.

What is not observable in this balancing act is the role of compulsive behaviour; the role of pleasure seeking and its relationship with health seeking behaviour. Mothers viewed themselves as responsible for their children's health behaviours and aspired to a healthy family lifestyle but the influences and pressures around them resulted in a continuous balancing act of healthy and unhealthy behaviours.

Whilst benefits of a healthy diet were recognised by mothers, an active lifestyle was viewed as a responsibility or even an ideal. The discourse around engaging in physical activity focused principally on the mothers themselves with various types of balancing acts by which mothers described their efforts against inactivity. In this respect, the negotiations over physical activity differed from those on food as here, remaining inactive is not based on a conscious choice whereas eating unhealthy treats for example is more clearly a choice to be rationalised. With regards to physical exercise, the mothers tried to combat their initial tendency to avoid doing something due to not being able to find the time or the energy needed. As a result, the negotiations mother's presented were in the form of trying to balance their tendency to avoid or make time for physical activity with their responsibility of providing an active lifestyle.

By far the most frequently used category was that of not being able to balance their routines to involve physical activity, whether it be walking instead of driving or attending a prearranged activity. Whilst physical activity was viewed as enjoyable and pleasant, especially swimming or single sex group activities, time after time mothers had to balance their commitments in order to find time and motivation to engage in formal activity, suggesting that the tendency to stay inactive is fairly persuasive.

The second category of finding balance in regard of physical activity stressed the value of physical activity, such as health or psychological benefits. These accounts did not contain a clear view that activity would be pleasurable as such. Instead, exercise produces other values, health or wellbeing particularly group exercise as it also has social benefits attached. Inactivity is less an outcome of rational or irrational actions than it is a response to living in an activity adverse environment promoting sedentary lifestyle (Crossley, 2004, Smith, 2002). Inactivity was persuasive for many mothers as remaining inactive was presented as convenient. Inactivity was not described as a particularly desired state instead accounts of frustration were related to situations where physical activity sessions were not at a convenient time, child care was not available or they did not have enough motivation to exercise on their own. Consequently, their frustration was connected not to

physical displeasure but to frustration due to lack of time and motivation. In the instance of physical activity, mother's attitudes were balanced by the view that it is more convenient to stay inactive than to be active but this preference should not be the only guide for making regular decisions. Instead, they should push themselves or find motivation to balance their lifestyle to be more active in between family duties.

4.4 Summary

In this chapter the emerging theoretical formulations are spelled out and explored. This interpretation is devoted to an examination of the categories and the key properties and relationships are discussed showing how the final categories interact to produce the theory. The research discussed has shown some theoretical consistency to this theory, or offered in places explanation of it and either directly or indirectly raises concepts with some relationship to this interpretation. The next chapter is where the grounded theory is discussed and implications drawn.

Chapter 5. Discussion

In this chapter some of the key elements of the interpretation and the grounded theory are discussed. Here it is important to understand how the theory developed contributes to understanding of the phenomenon under investigation and what may be the practical applications of the findings. Additionally, the opportunity to reflect upon the focus of the study and what this tells us about our assumptions of the phenomenon.

5.1 Interpretation of the findings

The grounded theory explored South Asian mother's perceptions of a healthy family lifestyle. Data from the interviews generated three distinct categories (*cultural identity*, *health beliefs* and *barriers*), which describe the influences and pressures affecting how South Asian mothers engage in a balancing act to negotiate a healthy family lifestyle. This provided a deeper appreciation of the way in which behaviour is connected to the cultural and social world through symbols, which are packed full of value-laden meanings. A number of patterns of negotiation were identified to represent a broad framework for describing the process of the balancing act mothers engage in, as well as a number of concepts and behavioural determinants. Lastly, the development of a model representing a grounded theory of the balancing act South Asian mothers go through to negotiate a healthy family lifestyle. The model identifies a hypothetical set of relations, which in the case of behaviour change identifies those relations that can influence a specific behaviour. How they negotiated the central phenomena depended on their confidence (i.e. belief in one's ability to perform the behaviour) and motivation (i.e. one's desire or will to engage in the behaviour). The result was that mothers were constantly engaged in a balancing act for a healthy family lifestyle. That process was not a single action but the outcome of taking into account external influences, behaviours, culture, values and meanings, and processing them. The theory developed facilitates an understanding of the unique way meaning of such behaviours develops for South Asian mothers in the context of the central phenomena. In particular the impact of cultural

determinants on behaviour and concepts that may be specific to the South Asian psyche.

5.1.1 The role of cultural determinants

Health related behaviours embodied latent social, cultural and value laden meanings that mothers incorporated into their ways of thinking but of which they were not always consciously aware. This study indicates that cultural attitudes to lifestyle change can be difficult to overcome which is a finding reported in other qualitative studies (Vyas et al., 2003, Grace et al. 2008). Although as with race and ethnicity, culture is a dynamic construct in that shared understandings change over time as they are shaped or informed by the experience of individual members of a group or the entire group (Caprio et al., 2008). There were numerous signs of acculturation including regular engagement with western dietary behaviours such as fast food which is a concern as we know the frequency with which fast food is consumed has been shown to be linked to increased body weight and obesity (Pereira, Jacobs, Van Horn & Slattery, 2005). Various traditional practices had lost value and desirability due to their unhealthy nature. The narrative around the retention of traditional practices, family roles and responsibilities highlighted both potential facilitators to a healthy lifestyle (e.g. the importance of family meals and home cooked food) and barriers (social consumption of food). Culture offers meaning to a set of rules of behaviour, that are normative (what everyone ought to do) and pragmatic (how to do it) whilst being a complex interaction of multitudes of factors that give a people an ethnic belonging and also have an impact on their lifestyle and predisposition to chronic disease (Khunti, Kumar and Brodie, 2009). Common feature of the mother's lifestyle centred on good hospitality and socialising with food and common barriers to changing behaviour included social expectation of special foods, a need to cook in compliance with their culture's expectation, the mother's role as provider of tasty meals versus guardian of family health, and the desire to exercise versus anxiety of not fulfilling their role as a mother. Factors such as these led mothers to express the issue in terms of their lack of control and inability to resolve these issues.

Given the broader role that the shared consumption of food plays in community life

these cultural barriers may be more likely to be overcome by involving the whole family delivering education, advice and support to the whole family may act to increase motivation through shared support not to participate in unhealthy cultural acts. This knowledge is important for health professionals and policy-makers as unfortunately ethnic differences in chronic disease, such as that reported in South Asians in the UK, continues to be an area of considerable health inequality. Health inequalities cannot be tackled by having an equitable health service for all, as it will not address the deep-rooted influences including cultural influences on health behaviours in this 'at-risk' group. This study also highlights that cultural influences need to be understood and taken into account when designing and planning interventions to prevent obesity and related diseases in this community. Guidelines for professionals have recently reflected this advice, (National Institute for Health and Care Excellence, 2012) recommending that lifestyle change advice should be tailored to different groups particularly minority groups, as their uptake of health information is lower than other groups and under-researched. There is now some consensus that it is important within a health professional's role to be sensitive to patient motivations and cultural commonality. Making lifestyle advice more culturally appropriate may enable South Asian mothers to put the information into practice, as professional's advice can lack acceptability and therefore be unlikely to be followed.

5.1.2 Concepts for the UK South Asian psyche

In terms of behaviour the concept of motivation (to resist temptation of valued practices) was more closely linked with being active whilst dietary behaviours were more closely aligned to the concept of confidence and motivation (to believe they can go against views of peers). Hence making healthy choices required a great deal of motivation on the part of the mother which led mothers to engage in a balancing act of healthy and unhealthy behaviours. Motivational factors and self-efficacy have both been identified in the literature as being important in intention formation (that is, an individual's commitment to perform a specified behaviour). Intentions express a person's motivation to achieve a specific goal. Intentions in turn are associated with behavioural outcomes, though self-efficacy is believed to have an independent influence on behaviours beyond its role in shaping intentions. Mother intentions and

plans could only influence behaviour if they generated sufficiently strong wants or needs at the relevant moment in order to overcome competing wants or needs. For example, mothers plan to engage in and encourage healthy eating behaviours and fully intend to oversee and monitor their child's intake but if there is a stronger competing desire (e.g. wanting to show gratitude to a mother-in-law through over-consumption) then intentions lose out to these desires. Considering motivation to change in more detail, it is clear that it involves both reflective processes (i.e. the self-conscious intentions or plans we make and the beliefs we hold) and automatic processes (i.e. our wants, needs and impulses). The balancing act involves being able to deliberate and reach a mutually satisfactory agreement, which requires reflection on the part of the mother, to understand their behaviour. Looking at motivation and behaviour in this way allows us to understand why mother's intentions often do not translate into the planned behaviour and instead end in compromise.

There are many theories of behaviour change that include concepts relevant to motivation and confidence. One factor influencing an individual's motivation to change may be confidence in undertaking a particular action. Once the individual has decided to take action, self-efficacy is important in order to sustain the effort required to maintain the behaviour and cope with barriers that arise. Therefore, building confidence is important if intentions are to be translated into actual behaviour change. Other theories such as self-regulation theory, goal theory and control theory attempt to explain how motivation is translated into action. These focus on the mechanisms by which an individual can undertake actions to affect their own behaviour and usually involve self-monitoring together with awareness of the goals or standards they have set. However, concepts such as self-efficacy or empowerment where emphasis is placed on individuals and their self-efficacy (e.g. Health Belief model) may not be readily applicable to South Asian mothers. This requires considerable motivation to overcome social pressures and prioritisation of health by the individual, but when the benefits of engaging in health related behaviours are not readily identified and long-term health not a prioritised goal. We are all strongly influenced by the people around us, our families, the communities we live in and social norms but for South Asian families this may be more significant. Research on the powerful effect of social norms on individual behaviour suggests

raising awareness and information alone may be insufficient to effect change in behaviour. For example, whilst mothers intended to encourage their children's healthy habits they were clear that in social situations their intentions to control were lessened or removed by their desire to engage in social norms.

Ultimately, this group may not identify with the westernised messages of health and perceptions may be at odds with individualistic motivations in commercialised healthy living and with current models of behaviour change. Therefore by encouraging behaviour change through information based interventions mothers would likely respond poorly as collectivist societies whose values are oriented to duty tend to follow shared norms and invest in relationships with other people (Cote & Levine, 2002). Strategies that only emphasise individual change neglect an important aspect of this population, collectivism. For instance, when considering a value system around food choice for South Asian families reinforcing factors centred firstly on social benefits and secondly physical benefits, which may be real, imagined or vicarious rewards. Hence, using more mainstream messages without addressing significant influences of the culture such as heritage, life experiences and cultural beliefs may act as a disincentive in disease prevention (Airhihenbuwa, 1992). This may only be possible if the group via a family or wider group intervention takes on these values. In addition, evidence highlights the importance of the whole family as the target for the intervention particularly important in South Asian communities where extended family members frequently play a key role in feeding and shopping (Pallan, Parry & Adab, 2012).

A concept that may fit with the South Asian psyche is Motivational interviewing (MI) a 'client centred directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence' (Miller & Rollnick 2002, p.25). It is used to coach individuals to modify their health behaviours. There are two main phases to MI firstly, building motivation for change and secondly strengthening commitment to change. MI draws on multiple concepts of behaviour change (both explicitly and implicitly). The professional engages the client in what is referred to as 'change talk'. This involves the person themselves identifying and communicating the reasons for change and might involve talking about the disadvantages of the status quo, the advantages of change, optimism for change, or their intention to change. Once the professional has established that the person is willing to change i.e., they are

sufficiently ambivalent about the status quo that they are motivated to change things – then the professional asks the person what they are going to do about it. They then negotiate a change plan. At this point family could be involved in the exchange and be jointly involved in setting goals, devising change options, arriving at a plan, and then prompting commitment together.

5.2 Implications and recommendations for research and practice

This study helped acquire an improved understanding of the reasons underlying food and activity choices by UK South Asian mothers and a model which can help professionals and educators to recognise the unique needs of this group and help them to find a healthier lifestyle balance.

5.2.1 Early intervention

Current obesity prevention strategies for UK South Asians are focused on adult life with interventions designed to reduce obesity in high-risk adults. However, it is important that such interventions which help prevent diabetes and coronary heart disease in South Asians start early, and given the importance of the extended family in terms of lifestyle choices should involve both the family and their wider family or community. Intervention is costly but likely to be cost-beneficial in the long-term for this particular group. Demonstrating cause and effect in relation to overweight and obesity, affected as they are by such a wide range of influences, will always be difficult and there is some way to go before there is convincing evidence of cost-effectiveness across a spectrum of approaches. There is limited evidence for effectiveness of interventions in adulthood when lifestyle behaviours are already established. However, childhood presents a window of opportunity to target obesity-related behaviours. As children's habits in relation to food and activity largely reflect those of their parents, encouraging behaviour change among adults could have a positive intergenerational effect. Such interventions have previously been based on Western behaviour models meaning no information regarding the cultural appropriateness of these exist. Compared to the Western focus on the individual,

relational and family-orientated, non-Western traditions may influence the relevance and uptake of health promotion messages within this group. For example, where overweight and/or its health implications are not recognised, interventions may benefit from adopting a healthy lifestyles rather than a weight approach to reach South Asian families.

This is important as contemporary health promotion in the UK is built on assumptions of individualism and self-investment and there is a drive for individuals to take greater responsibility for their own health. Therefore, it might be that instead of trying to impose a predefined concept of 'health' upon South Asian families we should attempt to validate their own perceptions of risks and values. So consideration of how this community can shift their behaviours from risk to health and still be desirable is important. Equally, consideration of the way in which healthy behaviours and lifestyles can be seen as 'better' than risky behaviours might assist South Asian mothers' decision making.

From this study it was not clear if awareness of ethnicity specific health risks would increase motivation. For some communities it is necessary to present information that is relevant to their culture. The term 'culturally sensitive' has been widely employed to describe initiatives which have been tailored to increase their appropriateness for minority ethnic communities. However, understanding the factors to be taken into account in developing tailored interventions is still developing within a wider context of competing theory based approaches. The greatest challenge lies in the development of culturally appropriate interventions using a community approach. Likewise, it is important to consider with this group the nature of social support networks, essential for promoting health behaviour change, i.e. extended families living within households or nearby, as social support from family members will encourage healthy diet and physical activity adherence. In order to achieve this, it is necessary to take account of the complex psychological and psychosocial dynamics of such behaviours and thus to formulate strategies in a language that is meaningful to individuals. Mainstream interventions often use only health education, awareness, and behaviour change approaches to improve individual and small group behaviours. This is unlikely to provide long term success

and therefore unlikely that large scale campaigns are reaching South Asian groups who look to their peers as role models and advisors.

5.2.2 Culturally tailored interventions

The explanatory model provides a framework to understanding psychosocial factors that impact on South Asian mother's negotiation of a healthy lifestyle until the behavioural determinants are managed. Basing an intervention on a specific theory can influence intervention effectiveness via the selection of specific behaviour change techniques (BCTs) or a combination of these techniques that prove effective, tailoring BCTs to groups based on their theory relevant characteristics. This theory underpins human behaviour and can help to inform the development of interventions to change behaviour in South Asian families with young children. If empirical evidence supports theoretical predictions that improving perceived control along with motivation and confidence as important factors in behaviour change then it will enable interventions to be developed that target these determinants more effectively. How this relates to the initiation and maintenance of a healthy lifestyle will be of use to health professionals and service providers in addressing and preventing health inequalities among this group also to researchers as there remains little evidence of successful interventions among South Asian groups particularly for South Asian children. For instance, physical activity whilst identified as a main factor in the aetiology of obesity for adults was not viewed as an important determinant in lifestyle related disease. This lack of association should cause concern for health providers as lack of knowledge and perceived lack of control over health implies behaviour modification is likely to be harder among this group. An improved understanding of the formation of parental perceptions of health risk may inform how health professionals can better communicate the risks of overweight to parents and increase engagement with intervention efforts. More specifically a need for understanding different ideas on body image in relation to health risks will likely assist behaviour change.

This qualitative research helps to reveal how social and cultural forces shape health behaviours and works to explain why information and programmes alone are often not enough to change it. Therefore, focusing on cultural influences and the integration of cultural beliefs and experiences along with providing culturally sensitive messages by culturally competent educators may prove to be a more effective strategy for addressing minority health issues, particularly among this minority population. This does not however imply that a one size fits all approach should be taken; the needs of the individual and family should be considered. For example, there are South Asian families who have a Sunday roast dinner, and rarely eat South Asian food. In terms of health promotion practices insight is important because the cooperation of those receiving strategies is essential and, in turn, if those receivers are to cooperate, then health promotion knowledge must be made accessible and meaningful. Therefore, information should be sensitive to South Asian concerns and motivations, such as those identified in this study and use of community peer education may be an effective way to assist levels of self-efficacy and provide reassurance.

For now health promoters may need to consider working with, rather than against, cultural norms, values and individual perceptions. For instance, rather than appealing to the promotion of individual health and personal gain, they might consider emphasising the benefits of physical activity and dietary change in terms of helping people to maintain their roles within their families and to fulfil their obligations to others. It may be sensible to invest energy and resources in raising general awareness through group and community based initiatives spread in particular through word of mouth as a useful approach for promotion. Supporting initiatives which receive community endorsement may help to alleviate mother's anxieties about taking time out from their obligations to perform exercise for themselves. Improving social support combined with providing information on ethnicity specific risks could be used as a key driver for improving motivation amongst mothers to reject unhealthy social and cultural norms. Positive health practices may then be influenced by individuals, families and the community by understanding ethnicity specific disease risk allowing for the empowerment of people, families, and neighbourhoods within South Asian communities.

South Asians living in the UK are a heterogeneous group with different religious (Sikhs, Muslims, Gujarati and others), educational and socioeconomic backgrounds, determined by their native country and the reason for migration to UK. Despite this study shows there are factors especially related to South Asian culture which are common and have an impact on risk of developing lifestyle related disease such as coronary heart disease and type 2 diabetes. Therefore, proactive targeting of information is needed, combined with specific guidance around South Asian specific health risks including being more susceptible to obesity related disease at a lower Body Mass Index, childhood obesity and earlier manifestation of disease. Guidelines (NICE, 2013) now recommend practitioners ensure members of the South Asian community are aware of this information. The dissemination style of this information is very important and use of existing South Asian information networks, use of local newspapers, online social media and local radio channels targeted at these groups. Also make use of local shops and businesses, community workers and groups, social establishments, educational institutions, workplaces, places of worship and local health care establishments, for example, hospitals as mothers often escort family members with diabetes to the hospital.

Nevertheless this study also shows the need to address misperceptions about the risk of diabetes and other lifestyle related diseases that could act as a barrier to change (hereditary rather than genetic nature of diabetes). This includes the belief that illness is inevitable (fatalism) and about what constitutes a healthy weight. Child obesity in general, parents displayed a greater knowledge about the need for a 'healthy' diet to prevent overweight than about the need for an active lifestyle. This is worrying as research shows that signs of differences in risk are already apparent in young South Asian children aged 9-10 (Whincup, et al., 2002). Offering this community support to improve their diet and physical activity levels, and ensure they are aware of the importance of both. Active travel could be promoted in this group.

5.2.3 Areas for further research

Research into South Asian health behaviours has mainly been driven by the increased rates of lifestyle related diseases in the older South Asian population, how they deal with lifestyle change once diagnosed and the processes of negotiation or

concessions made of cultural values and beliefs to enable them to engage in a healthy lifestyle. Researchers and commentators in the field of ethnicity and health seem divided over whether work should be empirically or theoretically driven to examine the links. Literature around prevention and health beliefs in currently healthy and younger generation South Asians is scarce and has not been prioritised. Also, there are few UK based studies on ethnic differences in obesity promoting behaviours in children and few studies have assessed the relationship with lifestyle behaviours, which may provide an insight into the underlying drivers of obesity in these groups. Learning about what may contribute to increased risk of childhood obesity in this group is a critical research issue as once established, obesity is notoriously difficult to treat, so prevention and early intervention is very important. Whilst the increased rates of overweight and obesity in children has been a major public health concern during the last two decades, due to a considerable lack of research involving families of different ethnicities living in England, there is limited knowledge about the factors that may contribute to risk of obesity in children of different ethnicities. Understanding the potential contribution of lifestyle factors on obesity related disease risk in minority ethnic groups is important to developing interventions to reduce this risk.

The role of parents in developing a home environment that fosters healthful eating is key and among children and parents shape their children's dietary practices, physical activity, sedentary behaviours, and ultimately their weight status in many ways adolescents (Lindsay, Sussner, Kim & Gortmaker 2006). We know children's dietary patterns are developed at a very young age and heavily influenced by the parent and home environment (Birch & Fisher, 1998). Parents can influence children's eating and physical activity behaviours in a positive or negative way by role modelling during the early years. Yet, the impact of family life on young children's eating behaviours is a neglected area of research and there is a specific need to focus more on the process of family eating i.e. the how we eat not what we eat (Kime, 2009). Studies exploring the relationship between parental beliefs and behaviours related to child feeding and child overweight have previously focused on European-American populations (Birch & Davison, 2001) and there is no known research on the feeding behaviour of UK South Asian parents and their children. Also, relatively little is known about parental beliefs and feeding styles within specific ethnic minority

cultures in general (Anderson, Hughes, Fisher & Nicklas, 2005). Little is known about the nutritional composition of diets among British children of different ethnic groups (SAHF, 2009). More specifically, we do not know very much about the relationship between ethnicity and feeding practices as there are clear implications of ethnic differences in nutritional composition for future chronic disease risk. Pallan et al. (2011) explored ethnic and cultural norms related to obesity among the UK South Asians and concluded that those developing obesity interventions that target UK South Asian children need to pay particular attention to the psychosocial functioning of these children and the possible internal conflicts they may face.

Further research, ideally with large scale studies from UK South Asian populations are required to allow health professionals and public health campaigners to fulfil the aim of preventing premature mortality due to lifestyle related disease in the UK's largest ethnic minority population. Including a further exploration of perceptions of healthy weight and identify barriers and preferences to healthy eating and physical activity in childhood.

In the meantime a focus on ensuring healthier lifestyle messages that is consistent, clear and culturally appropriate. Ensuring they are integrated within other local health promotion campaigns or interventions and provide details of the local support services available. There are diverse groups living in England with experiences and behaviours that may be a reflection of their ethnic culture, the majority culture or a combination of both. It is important to gain a greater understanding of these groups so that professionals and services are better equipped to provide care for people with diverse values, beliefs and behaviours. More studies are especially needed on the cultural fit of different types of exercise and dietary regimens in South Asians.

5.3 Limitations and strengths of this study

Following the literature search I felt that there was a distinct lack of studies that provided information on health beliefs and behaviours in the younger South Asian population who are not personally facing lifestyle related disease. I felt that in bringing an interpretivist perspective to this area, I was able to provide an insight to much needed information for professionals and policy makers to focus on to

encourage preventative behaviours with this group. This depth, although small in participant numbers, is enough to extend and challenge some of the generalised findings previously generated by limited quantitative methodologies. Although there are certain limitations to this study presented here.

5.3.1 Representativeness

Qualitative research is often criticised for its limited generalisability (Mays & Pope, 1995). While there are many positive features to this study, results should be viewed with a degree of caution as replication of these findings in larger populations are needed. The sample of London based South Asian mothers with young children cannot be representative of these groups of women across the UK. Thus, the results should be situated with respect to participants' contexts, which are likely to have influenced the findings. Nonetheless, the aim was not to study prevalence of certain health beliefs and behaviours but rather to explore their thoughts, feelings and attitudes around a healthy lifestyle for their families and additionally to explore their experiences with and knowledge of lifestyle related disease. The semi-structured interviews schedules employed in this study may inform the design and development of quantitative questionnaires to explore this topic with bigger sample sizes.

All participants lived within areas of east or north London in communities where similar groups of ethnic minorities dwelled. The urban environment has been shown to play an influential role on lifestyle and as the majority of UK South Asians are in urban locations this provides a more generalisable theory. However, in common with other areas of interest relating to people of South Asian origin, it is important to bear in mind the heterogeneity of this broad ethnic group and to be aware that the attitudes and health beliefs of specific subgroups may not be common to all migrant South Asians. The theory must be recognised as an interpretation, although it is grounded in the data, accounts for the data, and offers a new, modifiable and potentially useful interpretation (Charmaz, 2006). Conceptualisations of health may be found to vary systematically among ethnic groups, but it is likely that different accounts are variously drawn according to social circumstances, and that people's ideas will change over time. People's accounts of their actions in relation to health

will vary over time and therefore listening to a person on one occasion does not imply that one can predict their action on another. We must therefore be careful when making inferences on the basis of people's accounts, which are invariably retrospective rationalisations constructed for the purpose of the interview.

Nevertheless, considering their health risks, understanding disease risks and importance of engaging in preventive behaviours are imperative for this group. The purpose of this analysis is not to make generalisations about South Asian groups; the size and variation within the sample do not permit us to do so. Rather, the study examined how South Asian mothers with young children negotiate health behaviours and the contexts in which they do so and more specifically influences on how mothers determine children's health behaviours. However it is important to reflect that such research mirrors hegemonic discourses that 'blame' mothers for negative child outcomes. Nettleton, (1996) suggests there is tendency for advice to be oriented towards women and the suggestion that women ought to take the responsibility for not only their own health but that of others is thereby reinforced. Public health interventions have tended to reflect these approaches, positioning mothers as central to reducing rates of childhood obesity (Warin, Turner, Moore & Davies, 2008). Such models have been criticised for assuming parents are willing and able to prioritise nutrition (Murphy et al., 1998) and for reproducing 'a hierarchical, unidirectional understanding of intergenerational relations, which highlights parents' responsibility for children's food and eating practices' (Curtis, Stapleton & James, 2011, p.429). In addition to diverting attention from the wider social determinants of health, such discourses fail to acknowledge children's agency and the role children themselves play.

5.3.2 Choice of methodology

As a practiced qualitative researcher, I have skills in interviewing parents with young children in particular; and this skill served me well in this research context and I believe helped me encourage interviewees to engage. However, interviewing presents numerous challenges to the interviewer. Not unlike other interpretive methods, as a researcher I must be aware of two potential biases: double hermeneutic and the Hawthorne effect. This *caveat* is not limited to the use of

grounded theory. Interpretive researchers must acknowledge this role and its potential for affecting the results (Walsham, 1995).

The first bias, double hermeneutic, as termed by Giddens (1984), suggests the subject of the research is influenced by the research and by the researcher. Given time, the subject will eventually learn from the research and modify his or her behaviour. In terms of the weaknesses of interviewing, Darlington and Scott (2002) suggest that these are best conceptualised as issues about which the researcher should be mindful, rather than inherent weaknesses. Interviews may tell us what people say they do, but cannot reveal what actually happens (Coffey & Atkinson, 1996, p. 19). This point is echoed in this study as the interviews may not have given me access to how mothers actually perform health behaviours. Although, Rapley (2004) argues that the interview data is simply a product of the interaction between interviewer and interviewee, and so by definition cannot be biased given that concerns about bias are based on the assumption of an external truth held by the interviewee.

The other bias is known as 'the Hawthorne effect' (Landsberger, 1958).

Landsberger studied the famous Hawthorne experiments to try to understand the extraordinary outcomes of the research. In doing so, he found that people have a tendency to act to please the researcher, and this can result in artificial results. Likewise, I wonder if mothers talked about control (or lack thereof) as an acknowledgement that they should control food intake based on the norms of the society in which they live but actually with no intention of engaging in that type of control because the social costs are too high. Hence, mothers talking about it because I as the researcher expected them to express approval of or support for (something) but without being sincere or having taken such action.

Numerous empirical studies of lay concepts of health have shown how people generally prefer to claim that they are healthy if it is at all possible (Blaxter, 1997). As Crawford noted in his study of lay health beliefs, most people tended to start off interviews by saying that they were healthy, 'reflecting a strong moral imperative attached to health and the normality of health' (Crawford, 1984, p. 64). Likewise, mothers in this study started conversations with this premise however as they elaborated they began to recognise this was not always the case and reflected more

on intentions and actual behaviours. The moral nature of health and illness concepts is clearly in evidence in what Crawford (1980) characterises as our increasingly 'healthist' culture in which an almost obsessive emphasis on health locates primary responsibility for health within the individual. In this context, healthy behaviour becomes 'a moral duty and illness an individual moral failing' (Crawford, 1980, p. 365). Therefore, as a researcher I must bear in mind these influences when preparing research, collecting data, and writing up and reporting results. On reflection the use of focus groups may have been useful as the group dynamics can generate new thinking about a topic which will result in a much more in-depth discussion and an environment of normalising behaviours so that mothers felt more inclined to open up on their actual behaviours and beliefs.

5.3.3 Challenges of using grounded theory

Grounded theory is a challenging and stimulating research methodology with the challenge of appropriately using literature, the circular nature of the constant comparative process, the demanding nature of data analysis, and the task of actually presenting a grounded theory to be the primary difficulties associated with the methodology as Backman and Kyngäs (1999) denote. Therefore, employing a grounded theory approach had key implications for me in the planning, managing and executing of the entire study. In particular, the concurrent nature of data collection and analysis means this process takes a long time. In practical terms this demands on going access to participants central to the phenomenon. Glaser (1988) himself stated the arduous process of grounded theory data analysis and argued that certain researchers are not suited to using the methodology. However, by making a firm decision on the Grounded theory perspective I chose to use at the initial stage I feel this helped my application of the theory.

I gained a real appreciation of the value of the grounded theory approach, both for its ability to produce useful findings and for what it teaches the researcher about analysis. I also appreciated Corbin and Holt's (2005, p. 51) description of grounded theory as 'a lengthy and time-consuming process ... a researcher must be willing to live with ambiguity until the analytic story begins to fall into place, which can be considerably late in the research process.' Given these challenges, I found as

researcher I learnt to conceptualise data fully and also tolerate confusion at various stages of the analysis. I agree with Heath & Cowley, (2004, p. 149) who suggest that novice grounded theory researchers need to 'set aside doing it right anxiety' by adhering to the principle of constant comparison, theoretical sampling and emergence and discover which approach helps them best to achieve the balance between interpretation and data that produce a grounded theory.

5.3.4 Reaching saturation

In a grounded theory study, theoretical saturation is sought where all of the concepts in the substantive theory being developed are well understood and can be substantiated from the data. As Creswell (1998) describes the researcher must try to set aside existing theoretical preconceptions and may have difficulty knowing when the data is saturated. While saturation determines the participant sample size, other factors may have contributed to how quickly or slowly this was achieved in this study. Charmaz (2006, p.114) suggests that the aims of the study are the ultimate driver of the project design, and therefore the sample size. Charmaz also suggests that a small study with 'modest claims' might achieve saturation quicker than a study that is aiming to describe a process that spans disciplines. Other researchers have also elucidated further supplementary factors that can influence a qualitative sample size, and therefore saturation in qualitative studies. Ritchie, Lewis and Elam (2003, p.84) outline seven factors that might affect the potential size of a sample:

'The heterogeneity of the population; the number of selection criteria; the extent to which 'nesting' of criteria is needed; groups of special interest that require intensive study; multiple samples within one study; types of data collection methods use; and the budget and resources available'.

To this, Morse (2000, p.4) adds, the scope of the study, the nature of the topic, the quality of the data and the study design. Equally, in this study due to similarities in the participants saturation was reached within a smaller sample of participants than previously anticipated. Similarities included participants all being from inner city neighbouring London boroughs where large South Asian communities reside. They

were all raising their families within the Muslim religion and all but one mother currently or previously held a job in the UK. Therefore these similarities have lent themselves to reaching saturation within the data from a small sample. Even after the analysis of three interviews the shape of emergent data began to appear. As Guest, Bunce and Johnson (2006) found of the thirty six codes developed for their study, thirty four were developed from their first six interviews, and thirty five were developed after twelve. Their conclusion was that for studies with a high level of homogeneity among the population; a sample of six interviews may be sufficient to enable development of meaningful themes and useful interpretations'. According to Dey (1999), the concept of saturation is inappropriate. He suggests that researchers often close categories early as the data are only partially coded, and cite others to support this practice, such as and Strauss and Corbin (1990, p.136) who suggest that saturation is a 'matter of degree'. They suggest that the longer researchers examine, familiarise themselves and analyse their data there will always be the potential for 'the new to emerge'. Instead, they conclude that saturation should be more concerned with reaching the point where it becomes 'counter-productive' and that 'the new' is discovered does not necessarily add anything to the overall story, model, theory or framework. They admit that sometimes the problem of developing a conclusion to their work is not necessarily a lack of data but an excess of it.

Generating grounded theory is very dependent on the interviewing and coding skills of the researcher. While I am not sure if carrying out more interviews would have produced stronger or richer data, it might have allowed me to refine my interviewing process. Looking back over interview texts, I can see where I could have advanced the data by exploring a concept further. In order to use Grounded Theory effectively, the researcher must adopt a non-traditional state of mind. Fernández and Lehmann (2005, p. 9) provided a list of seven principles which includes the need to trust emerging data without worrying about justification with the view that the data will provide the justification. A further limitation may pertain to cultural differences between me and participants being from a different ethnicity. Although I attempted to remain open to participants constructions, it is likely my lack of awareness of participants' cultural contexts rendered important aspects of their experiences lost within the analysis. Practically, I also learned about the difficulty of recruiting participants directly from the community; time was needed to locate very busy

women, to make contact, and to follow up the initial contact before their interest was lost.

5.4 Conclusion

Knowledge about the influence of beliefs and attitudes towards engaging in a healthy family lifestyle are currently lacking among this highly at-risk group. Therefore this study, through exploring perceptions, has helped to provide a unique insight into the psychosocial dynamics involved in the pursuit of healthy and risky behaviours in this specific group. It also facilitates an understanding of the way in which the meaning of such behaviours develops in the context of dominant cultural traditions and the resulting theory can be used to inform the selection and sequence of intervention strategies.

Evidently, a number of factors give South Asian mothers their unique sense of identity and belonging, with cultural preferences influencing family engagement with recreational activities and food choices. High importance was attached to group norms and social values and this influenced motivation and confidence to undertake particular health behaviours. In other words, their belief about their capabilities was important. This type of information is invaluable in terms of developing and delivering prevention programmes targeting this community and highlights that cultural influences need to be understood and taken into account when designing and planning interventions to address healthy lifestyles in this community. Whether people are healthy or not are partly determined by their circumstances and environment and while data can give us population characteristics, it cannot tell us the whole story. Qualitative characteristics of the community, such as how they view or perceive health and health behaviours, are also important as health status is shaped by a multitude of factors, including the characteristics and behaviours of individuals and the physical, social and economic environment. This study contributes to an improved understanding of the factors underlying how young South Asian families engage with healthy and risky behaviours.

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SECTION B PROFESSIONAL PRACTICE

Professional skills case study

Introduction

The journey I have taken as trainee Health Psychologist (tHP) has involved learning, evolving, evaluating and refining my practice for continuous growth as a professional and as a person. During this journey, my work placements have varied from part-time research and health improvement roles to delivery of direct patient care through psychological interventions. Here I draw upon examples during my training that show my professional development and reflection upon skills achieved.

Communication

The process of describing myself as a tHP was initially a challenging task. Health psychology is a broad discipline and I was uncertain what it would entail for my practice, colleagues, and clients. I took time to consider what this meant to me and with more experience began to gain confidence, which in turn helped me secure various exciting professional opportunities (*Appendix A for my curriculum Vitae, p.236*).

Communication is a central means for exerting influence and in turn influencing power. I reflected during large multidisciplinary meetings I often came away discontent with the outcomes and frustrated at not influencing the situation through effective communication. I recognised I was not valuing my knowledge, finding my voice and importantly acting in the best interests of the public. I also reflected that some colleagues commanded or dictated terms, which negatively affected the group dynamics. This was not conducive to dialogue and was partly why I had struggled to voice my opinions. I decided to attend meetings having systematically prepared to try and improve the direction and progression of the meeting and to negotiate clear action points. To do this well I needed to be self-assured something I find difficult to do so whilst each meeting has an agenda I decided to write my own agenda to help me convey my thoughts in a more focused and concrete manner. I did this by providing specific details, supported with concrete examples so when sharing my observations with colleagues my input was more succinct, precise and relevant to better supports actions. A statement I find helpful to remember is, 'confidence is a

belief in one's own abilities to do something in a specific situation. This belief includes feeling accepted and on equal terms with others in that situation' (Eldred et al, 2004, p.6). Observing the dialogue of experienced colleagues also helped me improve and understand the art of diplomacy. For example, to be forthright but with an upbeat attitude and endeavour to be a problem-solver. Through delivering presentations, teaching groups of different sizes and networking my ability to communicate effectively has been regularly tested. I often present at the joint school nursing and health visitor forum attended by 150+ nurses and senior staff. I have presented on various topics (*Appendix B, p.238*). I always seek feedback from my manager and colleagues for my development and because I feel a great responsibility for ensuring I have utilised my colleagues time effectively.

As a tHP I aim for equality of opportunity when working and as I work in multidisciplinary settings this requires me to be aware of other disciplines' theories, practice and ethical principles, and to find ways of respecting others' views whilst not always agreeing with them. For example, I co-facilitated workshops focused on skilling a diverse group of staff in Motivational Interviewing techniques. I tailored the worksheets for staff to use with their particular client group to support them to use the techniques effectively with their clients (*Appendix C, p.240*). Tailoring involves making a message more relevant to a recipient through using information known about an individual or a group, to which the recipient belongs, and tailoring messages tends to be more personally relevant and thus attract more attention (Kreuter & Ray, 2003). I have also delivered training (i.e. lifestyle advisor course, raising the issue of child obesity, smoking cessation level 1) to staff with differing levels of knowledge (volunteers, health professionals, early years practitioners). From the training evaluation forms and my own reflection I appreciated that it was important to refrain from using vernacular terms, acronyms and responding perceptively to all contributions made to reduce miscommunication. Regular practice has helped me to become more assured, accurate and fluent in my use of language and supported me to better sustain the audience's interest as well as appreciating the value of facilitating learning through the sharing of experiences. I now strive to provide multi-professional training opportunities (*Appendix D, p.241*).

I regularly develop and design health promotion materials and inform this process by speaking with parents and staff to obtain their views on service provision identifying beliefs, cognitions and regulatory processes that maintain or promote adoption of health-risk behaviours. Learning to be an effective communicator has been a necessary tool for acquiring information and importantly understanding the values and beliefs held by minority ethnic and disadvantaged groups. For example, I led a parent focus group to evaluate a healthy cooking course and had to use my communication skills to encourage parents, particularly those with English as a second language to share their opinions to obtain a balanced evaluation (Appendix E, p.242).

Improving partnerships is a key part of my role and I look to do this by sharing good practice, promoting services, raising awareness of different professions as well as matching particular messages to those I am communicating. To help me disseminate information centrally and reach as many staff as possible (*Appendix F, p.247*) I developed a monthly newsletter for staff working in the community with families and young children from which I have received positive feedback (*Appendix G, p251*).

Professional and Ethical issues

Professional relationships require awareness of power differentials between colleagues and clients. The pregnancy, better eating and activity trial intervention group sessions I facilitated often involved emotive topics (body image, miscarriage, health anxieties, affordability of healthy food etc.). Therefore, it was important for me to monitor aspects of these relationships to lessen misuse of that power. Initially, I lacked skill in dealing with emotive conversations but after reviewing each session with a colleague she helped me reflect on strategies to deal with this. At the start of each group I re-capped the ground rules (*Appendix H, p.253*) we had set together and practiced being empathetic but not superior, involving the whole group to provide support and advice to remove the appearance of power differentials. Within my capacity as facilitator I worked to ensure the environment created was a safe one for women to open up in and disclose personal information.

Staff appraisals provide the opportunity to reflect on recent achievements, to assess the reasons for strengths and weaknesses, to analyse the potential for progress and to develop strategies to make the most of current opportunities and create new ones. They also are an opportunity to raise professional concerns. Managers of different professions have managed me with assorted approaches to the appraisal process. I observed that worthwhile appraisals were geared to my future development as well as my current practice, addressing the question 'where does the person want/need to get to, and what is required to make that happen?' and I found were most effective when they were regular, linked to goal setting and continuing professional development.

Management skills

Reflective practice has enhanced my ability to action plan for success through setting and defining objectives and goals around becoming more efficient and effective. As Drew and Bingham, (2001, p.221) suggest for professional development, look back on an experience and make sense of it to identify what to do in the future. I developed work plans (*Appendix I, p.254*) to assist me in prioritising and charting progress, seeking feedback and support from relevant sources and to help meet targets. I am intuitively a multi-tasker but do not always consider how far ahead things need to be planned to be executed. Implementing the Healthy Child Programme with involvement from twenty-one Children's Centres means planning ahead is essential as I often receive multiple requests for support. I have learnt to respond promptly by detailing action plans within a timescale to help manage mine and other's expectations. Where I cannot implement an action point as agreed I now recognise attending to issues promptly limits the surfacing of issues. To help me establish priorities, I employ strategies such as writing minutes with action points (*Appendix J, p.257*) to help me make sense of what took place and to refer back to, helping me to be more effective. As Cottrell (2001, p.67) describes, 'it helps to clarify thoughts, describes emotions, to work out strategies, and to focus on your development and progress...'

As public health coordinator I manage a staff member, holding accountability for their work and productivity. Being in this position for the first time made me aware being a manager requires a distinct set of skills. Certain skills I have developed through

coordinating volunteers and leading projects but an initial learning curve was learning to communicate regularly – both informally and formally as a manager. Having been used to working autonomously on projects I changed my approach to be more sensitive to my associate's development and to consider what and how I should be providing support. I have had both positive and negative experiences of being managed and whilst the negative experiences were not rewarding they did offer me insight into bad management styles. Good management involves regular supervisory meetings for analysis, evaluation and review, establishing goals so that progression can be measured, even if only for personal development. I discovered leadership skills cannot simply be learnt on the job and leadership is important for setting standards and criteria, as without a strong sense of leadership, motivation to achieve is somewhat lost. Identifying areas for improvement is essential for professional growth so after raising my lack of management skills with my manager she encouraged me to apply to leadership courses and I gained a fully funded place on the NHS leadership academy Mary Seacole programme.

Professional autonomy

As a tHP I have a commitment to continue my professional development for myself and for clients. This can be viewed as a range of learning activities through which I develop to ensure I practice safely, effectively and legally inside the evolving scope of practice. Within healthcare settings I am often asked to assist, advise or consult on a variety of issues. Much of this is informal and in each of my roles I learnt new topics that I had to adapt my skills to (i.e. gestational diabetes, breastfeeding and childhood safeguarding procedures). It was essential I became knowledgeable in the skills and tools necessary to do my job so I sought appropriate training, advice and resources in a timely manner.

As a tHP I made sure I was clear about the nature of my qualifications and the limits of my skills, techniques and not conveying health-related information to patients that lie outside my expertise. I received many enquiries around pregnancy which were beyond my competence and in these situations I had a responsibility to refer the person or issue to an appropriately qualified professional and ensure the enquiry was followed up appropriately (*see appendix K, p.258*).

Reflective-practitioner stance

To enable professional development reflective practice is crucial however learning to use reflection effectively takes practice. At first, reflection tended to be a process of identifying and addressing weaknesses, responding to events that took me by surprise and a process of reviewing and problem solving as Moon (1999) describes is common when beginning reflective practice. I found a useful model to encourage my reflective process by Boud, Keogh and Walker (1985) which suggests the reflective process includes a returning to the experience ('what happened?'), attending to feelings ('so what'), and re-evaluating the experience ('what next?'). This process helped me become more adept at reflection (*Appendix L, p.259*) increasing the ease of constantly self-monitoring and regulating behaviour Glaser, (1988) describes expert knowledge as built up over time through perceptual abilities and knowledge organisation, which results in the ability to recognise familiar patterns and anticipate a range of consequences. Also, I found that just verbalising an issue out loud to a colleague helped me get to the essence of the issue and reflect upon the success and failures, more easily considering ways to adapt or change.

Regular reflection helped develop awareness of what I deemed to be good practice and to put the focus on how this can be measured by myself and my own personal values and beliefs rather than by others, frameworks and policies. Likewise, Kottkamp and Osterman (1993, p.19) describe a greater level of self-practice as 'a means by which practitioners develop awareness about the nature and impact of their performance'. However, I often found myself dwelling on the negatives and feeling like someone else might have accomplished more than me. Reflection helped me be aware that holding negative beliefs about myself lowered my resilience and ability to cope with the stresses at work. Consequently I tried exploring the positives and negatives in equal measures and to remind myself of the achievements I have made so far.

Working in a variety of organisations and professionals has helped me recognise the distinct perspective I can add as a tHP due to my knowledge of concepts and evidence derived from Health Psychology. Health Psychology is evidence and theory based so it has been important for me to attempt to keep up to date with this element. To enable this I receive updates from numerous related organisations

including the National Obesity Observatory and regularly read about new technologies, new methods of working, legislative changes and current literature. Working in the NHS I have found my knowledge of empirically validated interventions and measures has enabled me to suggest and make informed recommendations for improving practice. For example, whilst investigating the local data on mothers diagnosed with Post-natal depression I found that staff had various training needs around this topic and identified an opportunity for staff to be trained in a new evidence-based approach I had come across. I also contribute to discussions about the nature of 'evidence' in health promotion and public health and the elaboration of models for understanding behaviour and behavioural adaptations putting me in a position to support decision-making in my role.

In summary, being a reflective practitioner has taught me to act confidently, be positive and respect the knowledge of everyone I meet.

Dealing with issues

Learning to manage conflict has been essential as projects often involve diverse groups of professionals, organisations and stakeholders which influence how they work and how they want others to work with them, often leading to a mismatch of expectations. Working across organisations is often challenging and sometimes inhibiting, as I am the recipient of everyone's disputes. However, in my role I aim to bring about decision-making.

One particular conflict that arose was the high expectations children's centre had for health visitors to be the key reporters of safeguarding issues. This reporting procedure involves filling out a form detailing the parent and the professional's view of the families concerns and strengths. At the time Health Visitors were dealing with extremely high caseloads so finding the time to fulfil this role was difficult and meant they often referred families to other professionals to complete the form or half completed the forms themselves. Children's centre staff viewed the Health Visitors as lazy and/or unskilled. This problem had been on-going for a while and children's centres wanted the matter resolved immediately by imposing strict targets on the Health Visitors. However, I wanted to further investigate the problem for a longer term resolution. To gain insight into my behaviour in conflict situations I explored the

Thomas-Kilmann Conflict Mode Instrument (Thomas and Kilmann, 1974). I often use a 'Compromising approach' where I work to split the difference between positions and use some give or take to find a solution. This approach can mean that things do not get completed or resolved, as I would have liked. As the theory suggests in a competitive climate, I fight for influence and respect, acting more certain and confident than I feel. This means being less able to ask for information and opinions and less likely to learn what needed to be known. Therefore, in this instance I tried using a 'Collaborating style', where I actively sought to create new solutions that met both partners' interest without having to make the sacrifices involved with compromise. I went about meeting with all staff involved to explore the issues. I learnt to be assertive by making sure everyone understood that the conflict may be a mutual problem, and may be best resolved through discussion and negotiation rather than through reproach. I felt in this situation my psychology background was essential because I was willing to understand the real issues behind the figures by engaging in collaborative work effectively and it also helped me build alliances. However, some of the issues I came up against were staff afraid to admit ignorance and uncertainties to me so I continued exploring the problem, comparing options and justifying the option I selected to take forward. I then planned and implemented this option, reviewing progress and revising my approach as necessary.

Conflict often arises because professionals have a lack of knowledge about each other's roles, unrealistic expectations about what the other can do and being afraid to admit ignorance and uncertainties creates a judgemental atmosphere. In this situation my strength was providing an outsider's point of view without any emotional ties to see more clearly the situation and what would help. However, as I was privy to insider information from different sides I did sometimes have to watch what I shared. Learning to be assertive, take lead and becoming a better communicator and negotiator has helped me move discussions forward. As Kolb rightly notes (1984) '...do something, think about it, what you did, come to conclusions about what you did and plan to try again'.

Therapeutic Relationship and Process

For 2.5 years I delivered an eight-week lifestyle intervention to obese pregnant women within a hospital clinical research facility. I used initial 1:1 appointments with the participant to gauge whether they understood the rationale for the intervention, and respond to any questions or concerns openly and non-defensively in order to resolve any ambiguities. The therapeutic alliance is an alliance based on listening to the client without being judgmental or giving unwarranted advice. Establishing a helping alliance and having good interpersonal skills I feel were more important in delivery of this intervention than professional training in achieving positive treatment outcomes. An alliance is created through understanding, acceptance and respect. I became skilled at eliciting information from the participant to understand and enhance motivation. I measured this skill by the level of input I had to give during a session and the level the participants gave. A helpful technique for establishing the therapeutic alliance through listening is to use a motivational interviewing technique (Rollnick and Miller, 1995) known as reflective listening. I worked to motivate individuals to manage their health and adjust their lifestyle. However, sometimes when sessions started at 8am it was more difficult for me to be on the ball and this sometimes reduced my ability to form a positive alliance. In these instances I tried to ensure I allowed myself enough time to set up in the morning and prepare mentally.

Participants were extremely diverse and this required from me awareness of differences across culture and ethnic groups, and was key to sensitive communication. For instance, I sought a list of culturally relevant foods so I could support all participants to make healthy choices. Also, relevance of physical activity varies by cultural groups where organised sport or exercise classes may not be valued forms of activity. In this case a greater understanding on my part allowed me to work to the different levels, led by the participant.

Conclusion

Being a tHP has given my career direction helping me keep an eye on my goals, uncovering gaps in skills and capabilities and opened me up to further development needs. I have learnt and understood I am accountable for providing a service that is honest, and trustworthy, providing advice that is correct and up to date knowing the limits of my practice. Through the process of reflection I found self-awareness

helpful in decision-making and having had plenty of opportunity to work collaboratively, being a tHP inspired encouraged me to seek opportunities through new employers, projects and clients. Reflective practice helped me develop creative answers to difficulties by seeking a course of action to help rectify situations. I found it important to regularly receive and act upon feedback as I want people to enjoy working with me and to view me as practicing professionally and effectively. Reflective practice helped enhance my self-awareness, problem solving skills, ability to evaluate and also develop as an effective manager.

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Consultancy case study

Assessment of consultancy request

A colleague forwarded an email from the Epidemiology and Public Health department at the London School of Hygiene and Tropical Medicine, which invited interest from health psychologists to consult on a project relating to childhood obesity management in primary care (*Appendix A, p.262*). I promptly replied, as the topic is a key interest of mine, and was invited for an initial, informal interview with a senior member of the department.

During the interview I queried why an external consultant was required for the role and found out that the current research team was lacking expertise to deliver the qualitative components of the project. As Schein (1968) suggests to get the most out of the initial consultation, it is helpful to think in terms of Exploratory interventions: 'Can you tell me a bit more about the situation?' Diagnostic interventions: 'Why is this an issue now?' 'Why do you want to bring in someone from outside the organisation?' Accordingly, I asked what the nature of the request was and the client outlined the project aims, funding source and the research team. I listened carefully to the client, repeated the information, asked questions and took notes to ensure I understood information correctly. I was pleased when asked what I would like to achieve from the consultancy as this gave me an opportunity to remove any ignorance in the situation and explain my reasons i.e. I wanted to work with an accomplished research team to further develop my skillset and fulfil the consultancy competency of my doctoral training. I sought to assure the client of my skills and expertise as a trainee Health Psychologist and qualitative researcher, highlighting my involvement in other adult and childhood obesity interventions identifying my relevant skills. Having anticipated questions about my experience I had, prior to the interview prepared to define this and as Boulton (2003) describes to achieve successful consultancy you need vision coupled with a clear description of what it is that you do that people will pay for. The client commented I was more experienced

than other applicants he had met and he decided at that point he would like me to offer me the opportunity.

At this stage it was important to set out agreed personal objectives and decide upon what my relationship was to be with the employing organisation. I explained more about my doctoral qualification, raising awareness of all the competencies should there be any other opportunities related to them. When asked about the amount of time I could offer, I wanted to be realistic but when put on the spot I was also keen to appear favourably. Consequently, I said, 'potentially two days a week...' when realistically I should have stated one day a week and given a time limit (a year) depending on any changes to my job role. Next time, I will decide prior to the initial meeting what amount of time I have to offer so I do not feel pressured to respond without due consideration. After the meeting, I met with one of the research associates who provided me with background papers and further particulars about the consultancy. Afterwards, I wrote up the minutes from the meeting (*Appendix B, p.263*).

Following this meeting, I received an email detailing an initial role to deliver qualitative interviews with parents whose children had been classified as overweight or obese through the National Child Measurement programme. I was invited to the team meeting and having read the research brief was confident in accepting this request, as I knew it suited my skills and I would be able to perform satisfactorily. I referred to a checklist on 'planning a contracting meeting' (*Appendix C, p.264*) by Block, (2010, p.98) which assisted me in preparation for the meeting. Being a consultant was a new experience for me so I wanted and needed guidance on what information to elicit from the meeting.

Plan consultancy

At the planning meeting I was introduced to the team and it was important to build trust quickly as being an outsider I needed to establish credibility. Having received

the qualitative plan and draft interview protocol, I had prepared some open questions about the plan to show my enthusiasm and interest. Although, having just joined the project I focused on listening, as at this early stage decision making is best made by those closest to the issue. I did take the opportunity to enquire about specific guidelines on conduct, consent and confidentiality and what procedures they have in place in terms of lone working. From this meeting, I understood I only needed to take a limited amount of responsibility, as the full-time researcher would deliver the bulk of the interviews, whilst I would deliver between 7-10 of the further afield interviews in Bristol and Birmingham. It was important for me to participate in the planning stage to ensure I could meet their expectations. Having previous experience of working on a National Institute of Health Research project with a multidisciplinary research team I was primed with appropriate enquiries such as the expected timetable for completion. I also had some concerns over travel arrangements such as distance of travel and expenses and my availability to deliver the interviews and how much time they expected me to be available which I raised. They explained the planned schedule for delivery and offered to work around my schedule. I appreciated the flexibility they allowed me and that they understood my time limitations. The meeting ended after having set out my job plan as a consultant including duties, responsibilities and objectives with us agreeing to enter a mutual agreement to deliver the work together.

On reflection, I came away from the meeting slightly unsure whom I would be collaborating with and to whom I was accountable. In order to clarify such a situation, Schein (1987) suggests categorising clients into contact, intermediate, primary and ultimate. Contact clients approach the consultant initially, intermediate clients get involved in early meetings or planning next steps, primary clients own a problem, for which they want help. I should have clarified this at the time especially because the team did not include the original client from the first meeting so through my next conversations I successfully identified the contact, intermediate, primary and ultimate client/s.

Following the meeting, one of the researchers emailed me to inquire further about my level of experience as a qualitative researcher. I was disheartened by this request as I must not have displayed my experience effectually in our last meeting. However I also understood the importance of establishing a personal relationship of trust and confidence early on, so I provided a detailed outline of my specific qualitative skills and experience. It is difficult to assess a good qualitative researcher, as their skills are less tangible, for example the ability to deal with sensitive topics, knowing when and how to probe and prompt at appropriate moments in the discourse. I wanted them to feel confident in my capacity to deliver the interviews and I was looking forward to delivering on the project, proving and demonstrating my skills.

I agreed on contact arrangements with the primary client negotiating contact primarily via phone and email, as it was difficult time wise for me to travel to their office. I drafted a contract using the SMART formula process (specific, measurable, achievable and agreed, realistic and timed) and set my objectives to present within the contract (*Appendix D, p.265*) with the hope that by ensuring clear objectives on each aspect agreed by myself and the client this would hopefully avoid any problems arising later. The primary client and myself, the consultant signed and dated the contract.

Conducting the consultancy

I was given recordings of interviews previously conducted; this sharing of information gave me a clearer picture of the interview style and approach to aim for allowing me to work towards consistent data collection methods. However, I did not hear from the primary client for some time after and it emerged arrangements for NHS ethics took longer than expected. This affected the original agreed timeframe by a couple of months, I tried to be flexible and responsive to their changing needs but as the interviews were taking place later I was not as able to minimise stress and pressures created by elements of my main employment, doctoral plans and life events. However, I felt we did share responsibility for trying to deliver the project and make

the process work as intended even if the change in timings had been outside of my control. I attempted to make adjustments to deal with the competing workload but also important made known to them likely significant demands that may impact on my service delivery as a consultant over the next few months and possible need for time away from the work in hand.

When establishing systems to deliver the planned consultancy a problem arose when the primary contact set up interviews for me to deliver on days I was unavailable. I wanted to support the work to be completed and show commitment to the project, but it was important we worked collaboratively. I attempted to manage the conflict promptly, minimising any further miscommunications by sending the researcher a detailed spreadsheet of my upcoming availability. As I only spent 1-2 days a week on the project I tried to respond swiftly to emails and likewise the team were excellent at responding to my emails, which I appreciated and this matching of styles allowed us to work together in a timely manner.

Delivering this consultancy, I not only contributed my skills but also learnt and developed my knowledge of working in research. It raised my awareness of certain issues such as securing personal data when working from home and safety when lone-working. I was invited to meetings, departmental events and involved in the decision making process as much as possible; this gave me a sense of inclusion with the team. Also, by proactively sharing other areas of my expertise with the team I consequently received requests for support on other projects. I had numerous opportunities for continuing professional development such as writing grant applications, development of behaviour change interventions and understanding the process of publishing work. I was also offered a further five days of paid work to analyse a subset of the interview transcripts providing triangulation. This is a key role in the analysis, and one that needs to be provided by an experienced researcher so I took this request as a good reflection of the quality of my work. I was keen to take on the project as it was a piece of work that could be attended to in a fixed amount of time and I could complete from home. The team

took into account my availability and we estimated together it would take four weeks to complete. Arrangements were made for me to complete timesheets for payment.

The interview analysis was completed using the qualitative analysis software tool NVivo. It was important to recognise and work within the limits of my professional competence so I made the client aware I had not used this tool before. The client then arranged for me to access an online tutorial. Ten transcripts were saved onto my password protected memory stick to ensure compliance with data protection and ethics requirements with identification of participant information removed. Working from home did lead to a couple of time delaying issues such as accessing and learning to use the software without someone nearby to refer to for quick advice. However, I tend to feel for areas I am less sure on I should attempt to find solutions and obtain knowledge by taking initiative. Nevertheless, on reflection I could have used support from colleagues to ensure I gained the necessary skills in a timely manner. My final analysis was compared and contrasted with my colleague's analysis to decide upon the major and sub themes. The research team then arranged to meet and discuss the final analysis together. I was not too sure how much input they would like me to have in the final process so chose to act reciprocally by preparing my thoughts on the data but waiting for them to ask for my views. During the meeting it became clear to me that my colleague and I, who completed the main analysis were best placed to 'make sense' of the data and shared responsibility for facilitating the meeting. However, it was important the rest of the experienced team were involved in this process even just as observers to oversee the framing of data appropriately. The meeting involved some deliberation and reflexivity over the chosen themes and I noticed I now felt comfortable expressing my views to the group particularly after having discovered that disagreement can often be a source of new ideas.

For the final report, I wrote a brief summary of the role I played in the analysis and sent a timesheet detailing the hours of work completed. During this time I was also offered a part-time post for six months with the department to continue working on a similar study with an increased pay rate, which felt like a reward for my hard work on

the previous project. Unfortunately, I was not in the position to take this post having just accepted a full-time post elsewhere, however they asked me to continue working with them on a casual contract basis. I had to weigh up my busy schedule but decided I wanted to continue even if it meant relying on annual leave and my spare time to complete the work. I was nervous about being able to fulfil their expectations so in the spirit of the 'no surprises' approach, which underpins effective appraisal I met with the key researcher and relayed my concerns. I wanted to be open about the competing commitments and strains on my time. Then they went ahead making arrangements for a casual contract including research passport, off site remote access to servers and database.

Monitor consultancy

In terms of the reporting and monitoring framework for my work, arrangements for informal reporting were agreed, which included updates by email and phone. I fed back to the team after each interview whilst the interviews were fresh in my mind, emailing the recording along with any other comments or observations from the interview. After each interview I took the time to reflect upon my interview skills. For example, how effective I was at developing a good rapport with participants as rapport building enhances the researcher's access to the interviewees' lives especially when discussing sensitive topics (Dickson-Swift, James, Kippen & Laimputtong, 2007). When posing interview questions, it is important to allow participants adequate time to respond fully (Nieswiadomy, 1998) and from listening back through the recording I became aware of times I could have worked harder to achieve this. I tried to make clear the privacy and confidentiality rules before the start of the interview to help them share their experiences. Discussing child obesity with parents can provoke powerful emotional responses such as anger, sadness, embarrassment, fear and anxiety. Vivaly, I felt comfortable discussing the topic having worked with parents with overweight children before and was able to demonstrate care and empathy during the interview, which is essential in eliciting information from participants (Cowles 1988, Dickson-Swift et al., 2007). However, one parent was angry during the interview and it was difficult for me to know how to deal with this and whether to continue with the interview. Afterwards, I informed the

team about my experience and a colleague who had a similar experience gave me advice.

When issues arise it is important to be aware of the sentiments of my colleagues in terms of the research protocol so that I make decisions that reflect the goals of the team. For example, I was told to keep to the interview schedule closely but having travelled 2.5 hours to visit a participant who responded with very brief answers to all questions or had no response at all I did decide to use heavy prompting to ensure more information was gathered. I spoke with colleagues wherever possible to receive objective feedback, discuss events, and to learn from each other. I received constant recognition for my work from the primary contact client mainly via email, which made me feel valued and part of the team. I attended the final team meeting to hear about the submission of the project and close the consultancy with the team by extending my appreciation to them for the experience and equally they thanked me for my input. I provided the project lead with a consultant evaluation form I had composed to help me evaluate the quality and impact of my work and for the client to provide their feedback (*Appendix E, p.268*).

Evaluate impact of consultancy

In terms of my personal evaluation I felt competent and proficient in the work I delivered and this was supported by the feedback from the lead researcher who strongly agreed he would hire me again and recommend me as a consultant to colleagues. For me, one of the most useful experiences from the consultancy was working collaboratively within a multi-disciplinary research team towards a joint end goal. A mix of skills is important for a project like this and as a consultant I felt I was providing an essential component of this skill mix.

The appraisal process during the consultancy was an important source for me to monitor my personal development objectives. When starting the consultancy I had been apprehensive about whether my work was of the standard they were working to, as most of the team were post-doctoral researchers. However, this consultancy helped me gain a clearer picture of the skills I have to offer, be more confident in the

value of these skills and develop my research skills in a high quality research team. The positive feedback I received during the consultancy via email and verbally from the team helped me shed a lot of existential fear and as a result able to discuss problematic issues that can arise during consultancy work. At the end of the consultancy the client scored me highly on all aspects of the consultancy evaluation form and this has helped me become more confident and mature as a trainee health psychologist.

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Teaching and Training case study

Introduction

For this reflective account I selected the final teaching session of a series delivered at London Metropolitan University on the MSc Health Psychology module titled, 'Context and Applications'. This teaching experience demonstrates my professional development from initial first time teaching experiences to gaining and developing my teaching competence. The teaching was, 'The role of mass media in health promotion' chosen because, although not an expert in the area, I could offer sufficient insight, interest and enthusiasm to examine the topic at MSc level. Given the breadth of Health Psychology no one can be an expert in each and every area, therefore I considered myself as a co-investigator with the students, willing to take risks to explore areas outside my direct expertise.

Learner profile

Developing a learner profile is useful to do before getting too far along the path of determining learning objectives as this allowed the session to be designed to the target audience and address gaps identified. To establish learner goals I considered what they want to know, how the learners may use what they learn from the session and what goals they have in seeking teaching. A good understanding of the audience (I had taught them previously) helped me start the teaching process from where the learners are; what the learners already know and to use representations they are familiar with to make the learning experience effective. For their existing knowledge, I reflected as the learners and I are both educated in undergraduate Psychology we have a shared background, which reduces obstacles to clear communication. As Kaufman (2003, p.215) suggests, 'It is critical to take learners' current knowledge and experience into account'. To clarify relevant objectives and consider what needs and outcomes might be expected within the context of this topic I reviewed the current training requirements in the British Psychological Society MSc Health Psychology course and the module handbook.

Part of being an effective teacher involves understanding how an audience best learns (Lieb, 1991). Therefore, I considered Knowles' (1984) Andragogy

assumptions for teaching adult learners (*Appendix A, p.272*), which guided me towards the use of problem-based and collaborative rather than didactic learning techniques, (emphasising more equality between the teacher and learner). It was important to adapt my teaching style to the specific audience and to consider the learners being all adults are likely to be at least somewhat self-directed in their learning (Winefield, 2004). It helped me to consider this via the following questions, 'How can I identify learners' learning styles?' and 'How can I use learning style flexibly to bring about change in facilitating learning?' By asking these questions I reflected on different learning styles and considered how my facilitation of learning can accommodate different learning styles. Personal and cultural experiences of different groups of students may affect learning as having taught this group of students before I was aware of their diversity for instance; English is not the first language for a number of students. Accordingly, I considered how to respect the variability of their learning needs and how I might demonstrate respect for diversity, maintain fairness and promote equality as their teacher. I then developed a profile of the learners and their needs (*Appendix B, p.273*) so that their knowledge starting point was clear in pedagogical terms prior to the planning stage.

Learning outcomes and assessment methods

I took time to reflect on my expectations for the session because it was important not to assume learner expectations or knowledge match mine. Also, consider what I wanted to achieve i.e. To deliver a one hour session that provides a weighty introduction to the topic and is related closely to health psychology constructs and inspires exploration and consideration of the topic further. I tried to establish what the possibilities were for time, format and assessment methods and developed an outline of the session for students to view in the module handbook prior to the session (*Appendix C, p.274*).

Learning outcomes are the specific intentions of a module, written in specific terms and identify the essential learning to be achieved (Gosling & Moon, 2002). To frame the learning outcomes for the session I used Bloom's taxonomy (Bloom, 1956;

Anderson & Krathwohl, 2001), which helped me situate each learning outcome according to the cognitive processes involved in learning (remembering, understanding, applying, analysing, evaluating, and creating). Next, I phrased how each skill is performed by using active verbs to describe six chosen learning outcomes designed to further the outcomes of the module. This process helped me as teacher to focus on exactly what students need to achieve in terms of both knowledge and skills. Likewise to guide students in their learning by explaining what is expected of them, in turn facilitating them to get ahead in the learning process (Walsh & Webb, 2002). This also marks a shift from the content of a module or course (namely, what I teach) towards its outcome (what the student is able to do on successful completion of the teaching session). To support adult learning Knowles' (1984) recommends taking time to involve learners in the planning stage and readjusting the content to inform anticipated training needs and outcomes of this group. I took the opportunity to discuss with learners in a prior teaching session if any area of the upcoming topic they would like to study in more depth and what type of delivery they felt best supported their learning i.e. what type of participatory activities they found useful?

Next, I considered what evidence of student learning would best identify achievement of outcomes from this short teaching session (1 hour). The module assessment was an essay from a choice of two essay titles one of which I wrote based on the topic of Culture and Health (*Appendix D, p.275*). To address assessment methods for this individual session I explored various assessment types along the continuum of the formative learning experience and decided upon conceptual understanding (being able to apply knowledge and skills), to be assessed throughout the session through learning tasks. This type of assessment provides the information needed to adjust teaching and learning while the session is happening especially at times when I could not be sure if students have understood. In this sense, formative assessment informs both teacher and students about student understanding at a point when timely adjustments can be made (Garrison & Ehringhaus, 2007). These adjustments helped ensure students were achieving the learning goals within the time frame.

Teaching methods

To plan the session I referred to theories of teaching good practice and used evidenced based methods that suited the session content and audience type. Prigent (1990, p4) defines a method of teaching as, 'A particular way of organising pedagogical activities knowingly implemented according to certain rules in order to make learners reach specified objectives'. Theory supports every segment of learning time to have a specific goal helping students achieve the identified learning outcomes and particularly useful for this time-limited session. I selected Kaufman's (2003) teaching method to plan the session as this method supports the agreed learning needs and outcomes specifically of adult learners through use of six learning principles. One key principle is, 'Learners should contribute actively to the educational process'. This will then encourage a student-centred approach as Gibbs (1995) defines as the emphasis on the process and competence, rather than content. Importantly, this takes into account students are not passive, they come with their own perceptual frameworks (Erikson, 1984), they learn in different ways (Kolb, 1984) and learning is an active dynamic process (Cross, 1991). I aimed to help student's construct authentic knowledge via use of concrete examples relevant to their own experience, as Kaufman (2003, p.215) defines, 'Learning should closely relate to solving real-life problems'. Hence, I used current and prominent examples and anecdotes and the use of analogies helps create new connections rapidly with existing schemata to provoke interest and help conceptualisation. I followed Race's (1999) pointers for a memorable and interesting lecture, beginning the session by explaining why the topic is important and what it will cover, and ending with a summary of both these. The summary is important as forgetting takes place very rapidly following a lecture and active use of the content greatly reduces this forgetting (Gibbs & Habeshaw, 1989). Although I cannot immediately guarantee active use, I tried to foster active learning by providing the lecture references and suggested reading as a separate handout so students had something to take away from the lecture to act as a reminder.

I felt it important to represent myself honestly to the group at the start of the session, detailing my experience, my professional position and qualifications. I strove to ensure the session was not just about myself imparting knowledge to the learners as

lecture situations often invite passivity on the part of the learner. As Fishdun (2000) says adult learners resist learning when they feel others are imposing information, ideas or actions on them (Fidishun, 2000) and passivity needs to be counteracted if lasting learning is to occur. An audience's attention drops dramatically in a lecture after ten minutes of listening (Bligh, 2000) so I divided the session into short presentations of 10 - 15 minutes; with learning tasks with either open questions, or problems, which I put to the group, following each short presentation. Learning tasks provide reinforcement of the learning, and are useful after difficult sections of material or to use whenever learners look bored, confused or irritated. There was not enough time for challenging tasks (challenging tasks are typically complex and involve sustained amounts of time) but they were difficult enough to be interesting. I prepared answers to tasks for effective teaching, as it is never good to ask learners to do something not endeavoured myself. Also, to ensure realistic amounts of time for effective learning for students (Vella, 1994).

Sensory stimulation theory explains effective learning occurs when the senses are stimulated, particularly via the visual sense; learning can be enhanced (Laird, 1985). I used a PowerPoint presentation (*Appendix E, p.276*) to help stimulate the visual senses and allow me to cover a large amount of material within a short timeframe. They are also a staple of student lectures and so an expected feature by students. However, I was careful to aim for the right balance of information on the slides as too much information, while this can attract students' attention, reduces the learner's ability to understand and remember as cognitive overload can occur (Mayer & Moreno, 2003).

The teaching group size influenced planning of the session as a small audience (20) allows for an interactive session more easily. For two learning tasks I posed 'thought' questions to the class and asked students to discuss in small groups before soliciting responses from the groups to ensure each contributed to the task. I visited each group briefly to encourage involvement by all and ensure they understood the task. I actively affirmed contributions made either verbally or through my body language acknowledging their contributions, making sure learners know that they are

heard and that what they say is valued. Students are more likely to contribute their own thoughts and ideas if they know the teacher values them and if the learner is actively involved, then more connections will be made both with previous learning and between previous learning and new concepts (Brown, 2004). Kolb (1984) outlines the cycle of how adults assimilate useful information into their 'experience bank', is by reflecting on experience, relating these observations to past experience or knowledge, and testing them in new situations. I tried to provoke thought, through the use of questions and encouraging discussion of alternative theoretical perspectives as this encourages active learning (Exley & Dennick, 2004a) and also a balance of views. I aimed to facilitate well by engaging learners in negotiation through stimulation and monitoring of discussion however, I found myself sometimes controlling the discussion. Learning through discussion, if managed well (Jaques, 2000; Exley & Dennick, 2004b), helps students to alter their schemata, to elaborate and fine-tune their concepts and values. Therefore, I needed to allow students control over the discussion to ideally support meaning to be constructed within each student. The negotiation of meaning, which takes place in discussion, is a very effective way of constructing meaning (Vygotsky, 1978).

Although important to have a comprehensive teaching plan I tried to be flexible to the changing needs of the group during the session. For example, I attempted to match the level of intensity of the session to the group, so if the group were not responding and reciprocally confirming their knowledge then to change focus and make the challenge more manageable or the opposite if responding well. Having a clear voice and articulation, and varied use of tone of voice I feel is a strength of mine and helped support learning. However, I need to remember keep to a moderate rate of speech particularly for those with English as a second language and do this by getting feedback from students as I go along.

As a teacher, I am in the position of being a role model to students so need to ensure I am sufficiently prepared to deliver an effective teaching session. Taking account of the profile and learning needs of the learners, and relevant published theory and good practice I developed a teaching plan (*Appendix F, p.286*).

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Teaching evaluation

Introduction

The chosen aspect of my teaching and training is a session delivered to MSc Health Psychology students on 'The role of mass media in health promotion'. I purposefully selected this teaching session because it was the final of a series delivered on a module exhibiting the relevant stages through teaching and training competence. The process of gaining competence was an iterative process where I continually updated my knowledge through reading, critical observation of, and feedback on my efforts and through my commitment to improvement. I collected multiple sources of feedback from the previous two teaching sessions to inform this final session. A key to effective teaching evaluation is to collect data from multiple sources (triangulation), making sure that all education-related activities are rated by the people best qualified to rate them (Felder & Brent, 2004). By collecting information about what goes on in the room I teach, and by analysing and evaluating this information, I can hopefully identify and explore my own practices and underlying beliefs. This then led to changes and improvements in my teaching. Reflective teaching therefore implies a more systematic process of collecting, recording and analysing our thoughts and observations, as well as those of our students, and then going on to making changes.

Evaluation methods

I guided my evaluative goals by considering what questions I wanted to answer, 'How do I know it worked/didn't work? How else might I have done it? What will I do next time?' I then established evaluation procedures; to ensure training needs were being met and gauge the success of my teaching approach using evaluation at several levels as more than one component provides a more informative evaluation (Felder & Brent, 2004). With feedback I am able to demonstrate learning processes I went through, professional development and shaping of my teaching methods and style. An appropriate research paradigm to monitor my success as teacher is that of Action Research (Kemmis & McTaggart, 1992) as the model lays great emphasis on participation by all stakeholders (i.e. students and teaching team) so facilitates not

only active co-operation but also sustainability of the changes suggested (Altman, 1995). The basic steps of the action research process constitute an action plan to review my current practice and identification of aspects that I want to investigate. The crucial concept is that of a continuous spiralling process, which includes making realistic plans, their implementation, the observation of their effects (all of the effects: some will be unintended), reflection and discussion among all those affected, then formulation of further plans and the iteration of the cycle.

Action Plan

Observed practice

The MSc course director collected information about my teaching session by observing and note taking. Then provided me with an informative evaluation (Appendix A, p.290) on such aspects of my teaching as appropriateness of materials and methods, breadth and depth of material covered, the relation of such material to the syllabus and goals of the course, incorporation of recent developments in the discipline as well as style and pace of delivery. It provides evidence that bears on competence assessment using the criteria for the competence and then compared with students' perceptions offers a more informed appraisal of competence and mastery of content. Also, I took part in peer observation of my teaching style with fellow trainees, which provided a constructive environment for recognising the components of a skilful performance and helping me to notice patterns occurring in my teaching which I may previously been unaware and come up with some ideas for how to do things differently.

Student feedback

Feedback about my success or otherwise at times arose spontaneously from the audience evident through invitations to continue/expand/return to sections of teaching. However, to assess the learning outcomes and identify factors contributing to these outcomes formal feedback was necessary. Students are in a better position than anyone else to judge certain aspects of teaching, such as how clear, interesting, respectful, and fair the teacher is, and they are the only ones who can say how an instructor has influenced their attitude toward the course subject, their

motivation to learn it, and their self-confidence (Felder & Brent, 2004). There is also substantial research linking student satisfaction to effective teaching (Theall & Franklin, 2001). With this in mind I designed an evaluation form (*Appendix B, 291*), to acquire feedback on the teaching materials used, quality of delivery and perceived relevance of the teaching, as these areas will support my professional development. I endeavoured to not employ words with unclear meanings; double-barrelled questions; response alternatives which fail to exhaust the possibilities; etc. and my supervisor then checked its applicability. I used ratings only for a section of the form to explore student satisfaction but then to overcome 'death by questionnaire' as Race (1999) describes, 'include open questions to invite thoughtful responses and encourage open and honest views on the lecture in general, gaining more depth and richness to the feedback'. I reminded students about their anonymity as students must not fear retribution based on their feedback, or it will significantly inhibit their willingness to be honest in their feedback (Gordon & Stuecher, 1992). I read student feedback immediately after the session to give me ideas for changes to implement whilst the session was still fresh in my mind.

Self-assessment

After the teaching session I reflected on the process and outcomes using an inventory of issues (*Appendix C, p.292*) to help strengthen my reflection and consider factors contributing to the outcomes of the teaching sessions. As Braskamp and Ory (1994) advise a reflective analysis on the part of the instructor can be instrumental in promoting instructional improvement. The session was filmed, which gave me a chance to subject my teaching strategies, instructional techniques and style to my own critical evaluation. Self-evaluation caused me to reflect on my direction and methods promoting a sense of responsibility by encouraging higher standards as well as helping me determine my competence. This was useful to do on an almost constant basis early on in my teaching experience.

Evaluation analysis

I collected feedback from the evaluation methods and as Action Research proposes I took stock of what happened, imagined a way forward and decided upon relevant

modifications. The feedback received from students and the observer assisted me in learning about my strengths and weaknesses and to formulate recommendations for modification.

The session was time-limited so I was relying on the interactivity of the session to guarantee information was conveyed successfully. I felt students interacted slowly to some of the learning tasks but others I could tell were more successful as they were asking questions and being animated. Nearly all students strongly agreed the session helped their understanding of the topic and the majority of students rated the session as very interesting. When developing the learner outcomes I tried to keep abreast of up-to-date issues in health psychology to ensure the session reflected current matters as it is important to consider how I would answer a student who asks, "Why should I care about this stuff?" One student expressed enjoying the real-life examples used during the learning tasks and the opportunities for group discussion.

Discussion is an effective teaching tool, however it can be difficult to manage because, "discussion teaching is the art of managing spontaneity" (Barnes, 1994). I tried to promote discussion by being considerate of the learners needs allowing students to interrupt at appropriate times and continuing when a conversation went off topic and including all students, stopping some from answering each question, deflecting a question back to the group. Good practice in teaching describes encouraging active learning to help students make what they learn part of themselves. Active learning fully engages most students in a class instead of just the two or three who normally do all the talking; people learn far more through active practice and feedback than from simply watching and listening to lectures (Felder & Brent, 2008). The observer said, 'I elicited well from the group but the group seems to be a bit slow to warm up today so maybe allow them more time to come up with ideas.' It is important to be flexible to the mood of the group and consider students' attitude towards me as lecturer. In this instance, I needed to allow time for creativity to support the student's development of ideas without jumping in with my own to fill the silence. This requires confidence something, which I will work on by acknowledging this failing and building on through practice. Also, in the feedback one student suggested students bring in information to share and discuss within the

session. It is often easy to overlook simple activities such as these but this type of activity would have helped me interact more quickly with the whole group as students would have shared their examples at the beginning of the session helping them 'warm up' to me and to each other. Similarly, Johnson and Johnson, (1999) suggest giving individual students opportunity to react to the discussion through reports, journals, and evaluations, which may facilitate different learning styles.

To be an effective teacher I tried to ensure the focus of the session's learning outcomes were clear at the start and students knew what to expect by outlining clearly the session components. The learning tasks during the session were not only for supporting learning but helped me evaluate the teaching as I went along monitoring and adjusting instruction to increase learning of all students.

The observer felt the slides supported well what I was trying to get across which is important; it can be difficult to tell without an outsider's opinion. Feedback from a previous teaching session included more visual aids such as pictures, graphs and charts so I had increased these and felt this time round it was easier to keep the student's attention and gaze. The feedback positively supported this with nearly all students strongly agreeing the material was presented in a manner that facilitated understanding.

In terms of my performance, I am now aware I need to work harder to engage the whole audience and maintain eye contact with everyone. This will provide a more inclusive atmosphere and help me come across as warm, accessible, enthusiastic and caring, which is important to be an effective teacher. In this instance, I think with the session being shorter than normal, being observed and filmed meant I was not as relaxed. Also, with the shape of the room it was difficult to move around as the tables were in rows in a narrow room. I now know the physical circumstances I teach in can support or hinder the teaching process. From experience, I prefer a horseshoe seating layout rather than rows when delivering an interactive session as this allows me to alternate between the lecture and discussion formats more easily. Additionally, some groups finish early and waste valuable class time on irrelevant conversation; other groups may flounder for the entire interval, become intensely frustrated, and also waste class time (Felder & Brent, 2009). To be an effective

teacher organising the classroom will help me maximise academic learning time.

I had planned a few distinct points I wanted students to remember and this was tested by the feedback form, which asked for the most memorable pieces of information the learner took away from the session. The majority of students answered this question even if they did not answer the other open questions and gave one or two memorable points, which was positive. Next time, I will look to ensure that I refer more explicitly to research available and directly link into more Health Psychology. The observer suggested I needed to make the links more explicit, which I think I can improve on by practicing how I describe theory in context prior to the teaching session.

Conclusion

Through completing an in-depth evaluation of my teaching I have understood well the importance of regular evaluation to put me in control of my professional development and towards improving the educational experiences I provide students. It was essential to consider how to interpret feedback and I found it useful to discuss with peers, my supervisor and experiment with ideas for improvement. By learning to respond positively to constructive feedback and being open to evaluation this has supported my development as an effective teacher.

The student evaluation form was easy to administer and provided an insight into my skills as a teacher including communication, rapport, and effectiveness. However, anonymous evaluation did mean I could not clarify or elaborate on feedback afterwards and positive biases may impact the usefulness as students may not wish to risk overt criticism of a teacher if they know they will be seeing them again. The evaluation process assisted me in gaining a more authentic appreciation of what makes a good and effective teacher. Effective teaching demands broad knowledge of discipline and classroom management techniques and requires presentation of lessons in a structured and clear way. I think this will come with practice but it may take doing quite a lot of teaching for me to feel confident or comfortable enough to try more interesting, rewarding and educationally justifiable methods. However, for

the meantime I will focus on making my teaching as effective as possible to aid student learning and doing this through continual reflection and focus on good practice guidance.

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Reflective commentary on a filmed lecture delivered to MSc Health Psychology students

Reflective teaching via video recording provided me with a useful source of information by helping me look at what I do in the teaching room, think about why I did it, and think about if it works - a process of self-observation and self-evaluation. I may do things in the teaching room that I am not aware of for example, the recording helped me consider aspects of how I talk as a teacher (i.e. how much I talk, how I give instructions and explanations, and how I respond to student talk) and aspects of my own behaviours (i.e. where I stand, who I speak to and how I come across to the students).

Prior to commencing students were made aware whilst their voices would be recorded they would not be visible on the recording. I asked them to relay any concerns to me before obtaining their consent verbally.

The role of mass media in health promotion	
Aims	<ul style="list-style-type: none">• Look at the double-edged sword of health-related coverage by the mass media and its role in reporting risks to our health.• The outcome of different media reporting styles e.g. health scares such as the MMR vaccine or coverage of celebrity's choosing not to breastfeed.• The use of mass media for health promotion at community, national and international level and the psychological models underlying campaign strategies.• Topics for discussion include the media's responsibility in its portrayal of health-related matters and whether lay people can use this information to help them make informed choices about the way they live their lives.
Outcomes	<ul style="list-style-type: none">• Know the types and roles of mass media

	<ul style="list-style-type: none"> • Understand the use of media in advancing public health goals • Appreciate the complexity of communicating about health through mass media • Analyse the contribution of mass media to health promotion at community, national and international level. • Evaluate the beneficial and harmful impacts of mass media.
Learning Strategies	<ul style="list-style-type: none"> • As they are a small teaching group various learning styles can be accommodated including visual aids and participation from students and activities.

I presented an account of health messages in the mass media showing visual examples asking them to identify the health message from the adverts. When switching from delivering information to class participation I could have made this action clearer by verbalising this as an activity and describing the time they would be given to support student's to take more responsibility for their learning.

I explained common problems with health messages in the media using a clear voice, articulating words and a varied tone of voice. However, the pace of my speech was at times too fast and sections of information were too continuous without breaks for students or myself to pause for thought. At the end of sections of information I sometimes said, 'Ok?' to check students were still with me in terms of understanding. However, as it was a closed question students either nodded or did not respond. It would have been more useful to check understanding with, 'what does everyone think?' or, 'can anyone think of any other problems?'. Also, rather than me standing behind the desk I could have moved around the classroom to encourage participation from more students who were further from my gaze.

I presented case studies on mass media's role in public health scares. Students responded with interest nodding at the examples I presented. I presumed from this that they all recognised these health scares. However, I should have taken the

opportunity to check if more information was needed especially as it was a small class. Also, a couple of key points I made did not come across as clear and poignant as I imagined. This was due to overuse of vernacular terms which students are unlikely to have understood.

I opened a question to the class on whether health information in the media had affected their own personal beliefs. Students enjoyed the opportunity to give their own personal examples and contributed well, linking examples to their understanding of the topic showing good appropriation. However, to encourage more discussion between class members rather than students directing their responses solely to me I could have used prompt questions such as, 'what does everyone think...?'

I did not leave enough time for student participation as I leapt in and summed up points made. I need to be more comfortable with silences and aware of my behaviour in these instances. Students need time to digest information; as for some it may be completely new to them. Also, during silences in terms of posture, relaxing my hands would help display a more confident stance and invite students to participate.

Intervention case study

Aims and rationale

As Health Development Advisor at Bromley Healthcare one of my service outcomes is to encourage and promote increased rates of physical activity (PA) in line with Bromley's vision for the population to lead longer, healthier, happier lives, which translate into improvements in life expectancy, quality of life and wellbeing. In Bromley (an outer London borough) increasing levels of childhood obesity, lower than national average PA rates coupled with a growing population group of 0-4 year olds signified to me an urgent need to promote active lifestyles early in this group to help address the health challenges Bromley faces. The intervention developed will aim to encourage families to engage in Bromley's WalkingTogether programme as part of an active and healthy lifestyle, which will not only keep them fit today but also instil good habits for tomorrow.

Background

The growing increase in lifestyle-related health problems has emphasised a need for preventative approaches and the promotion of health behaviours. Health behaviours are behaviour patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement (Gochman, 1997). PA (a self-directed health behaviour) reduces the risk of coronary heart disease, obesity, hypertension, some types of cancer, osteoporosis, depression and anxiety (Department of Health (DOH), 2009). To achieve these benefits, it is recommended adults undertake at least 30 minutes of at least moderate intensity activity on five or more days of the week and children should achieve at least 60 minutes of at least moderate intensity PA each day (DOH, 2004). Even relatively small increases in PA are associated with some protection against chronic disease and an improved quality of life (Chief Medical Officer's report: Start Active, Stay Active, 2011). Physical inactivity is a leading risk factor for mortality and important throughout the life course so there is a need to increase levels of PA participation in both children and adults.

Current levels of PA for both adults and children in Bromley are below the national average and low PA levels play a significant role in the development of childhood obesity. Recent data shows rising trends in both the prevalence of obesity and overweight in children (National Child Measurement Programme Report for Bromley, 2011). Regular PA results in reduced body fat, promotes healthy weight and enhances bone and cardio-metabolic health, as well as enhancing psychological wellbeing. Research suggests that parental PA impacts positively on how much PA children participate in and plays a crucial role in the provision and uptake of healthy lifestyles by children. According to Welk, Wood, and Morss (2003), there are two aspects of parental behaviours that promote PA in children: (1) role modelling, which includes a parent's interest in PA as well as their efforts to be active, and (2) parental support, which refers to parental encouragement, involvement (i.e., participating in PA with the child), and facilitation such as providing access and opportunities for the child to be active (e.g., transportation to parks). Having had experience of delivering childhood and maternal obesity lifestyle interventions I am aware of the barriers families face to being active and the gap in family and community based interventions that encourage PA among families. The UK Physical Activity Guidelines (British Heart Foundation, 2011) recommends parents and carers should be made aware of the importance of physical activity for their children and encouraged to interact with them in a physically active way as often as possible as this will encourage a child to be more active, enjoy the experience and stimulate further participation. Parents are important role models for children and being physically active themselves has many health benefits too.

Whilst, school-based programmes have often been successful in improving children's PA behaviours in school, there is less evidence to show that it improves these behaviours outside school (Stone, McKenzie, Welk, & Booth, 1998). Indeed, researchers consider it unrealistic to expect schools to facilitate changes in children's behaviours without support from families (Wechsler, Brener, Kuester, & Miller, 2001). It is recommended that interventions should forge more community links to encourage increased PA out of school (Lytle, Jacobs, Perry, & Klepp, 2002) particularly as children spend a considerable amount of time outside of the school setting, during weekends and school holidays. While Bromley boasts a good

number of public parks and open spaces as well as sites of natural beauty and nature conservation very few activity initiatives are open to everyone (e.g. for any age, no cost attached) and continue throughout the year. The Chief Medical Officer's report on the evidence of the impact of physical activity and its relationship to health (2004), suggests the development of sustainable, cost-effective PA strategies is needed to meet health goals i.e. building on current schemes to encourage people to be more active. This led me to consider current schemes in Bromley to identify effective approaches and strategies that may benefit this target group to achieve more health benefits through active lifestyles.

The Bromley Walking together programme runs seven weekly 45 minute - 90 minute walks led by trained walk leaders. The walks take place within nature reserves or parks, providing a variety of walks i.e. wheelchair and pushchair friendly, toilets available and different speeds for strollers, medium and fast walkers. The programme runs continuously throughout the year, which is a distinct feature from many PA interventions or programmes that have a short-time period, or breaks in provision. The walks provide a foundation for people to build upon to become active and are especially appropriate for families being accessible, of no cost, outdoors, in local green space and running during the holidays. The age of those attending the walks is routinely in the range of 40-85 years old with a few children attending with grandparents. I explored online how the national walking programme had developed around the country and found an initiative called 'Take a parent for a walk', promoting parents and children to attend health walks together. As the summer holidays were approaching this provided an ideal time to target parents to stay active with their children over the six weeks of the summer by engaging them with Bromley's walking programme.

Assessment

Theory helps to explain the dynamics of the health behaviour in question, including processes for changing them, and the influences of the many forces that affect health behaviours, before being used to develop a set of assumptions about factors contributing to the health problem to inform the intervention. The Transtheoretical

Model (TTM) and Health Belief Model (HBM) were utilised in a questionnaire (*Appendix A, p.295*) to identify cognitive, behavioural and situational barriers to, and facilitators of, change and to identify motivators and rewards for PA behaviour.

The HBM was originally developed to investigate why people fail to undertake preventive health measures and is primarily based on Rosenstock, Strecher and Becker (1994) and is a health specific social cognition model (Ajzen, 1998). The key components and constructs of the model postulate that the likelihood of adopting a particular behaviour is related to an individual's perception that the behaviour will either improve or damage his or her health. Since health motivation is its central focus, the HBM is a good fit for addressing problem behaviours that evoke health concerns as it addresses the individual's perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy). The HBM proposes that the individual independent variables are likely to contribute to the prediction of health behaviours (Sheeran & Abraham, 1996).

The TTM (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1994) is an integrative, biopsychosocial model to conceptualise the process of intentional behavioural change. Its basic premise is that behaviour change is a process, not an event and uses stages of change to integrate processes and principles of change from across major theories of intervention. Behavioural change can be thought of as occurring as a progression through a series of stages. As a person attempts to change behaviour, he or she moves through five stages: pre-contemplation, contemplation, preparation, action, and maintenance. People at different points along this continuum have different informational needs, and benefit from interventions designed for their stage. The critical activities needed to move an individual through the stages are the Processes of Change: covert and overt activities people use to progress through the stage and Decisional Balance: weighing pros and cons of changing and self-efficacy. People do not systematically progress from one stage to the next instead; they may enter the change process at any stage, relapse to an earlier stage, and begin the process once more.

The HBM will be used to explore how parents feel towards the health problem (being inactive), whether they believe it is serious (the impact of being inactive), and whether they believe action can reduce the threat at an acceptable cost (whether including more PA into their families lifestyle has more pros than cons). The TTM proposes people are at different points along the continuum of change and by asking some simple questions of parents, I will assess what stages of contemplation parents are in and their responses will help to pinpoint where they are on the continuum of change, to help tailor messages, strategies, and programs appropriate to their needs.

Working with staff at local Children's Centre I delivered the questionnaire to six parents with young children. The results for the TTM questions showed one parent was in the pre-contemplation stage, four in the contemplation stage and one in the preparation stage. The contemplators suggested they had considered the benefits for their families of being more active together (pros: health and happiness) but found it difficult to regularly engage in physical activity with their children (cons: time, money, transport) so encouragement and information reinforcing the benefits would likely support them to reduce the cons of changing their behaviour. The parent in the preparation stage had decided her family needed to be more active and had already looked into ways to do so. The pre-contemplator felt that being active as a family would not be beneficial for the family's health. The HBM questions found parent's perceptions of being active with their children were perceived as difficult and unlikely for a number of feasibility reasons: difficulty finding activities suitable for the whole family and wanting to prioritise family spending time together, activities too expensive, poor weather conditions, no activities locally and distance from home and inflexibility of structured PA in terms of the time it's available. Three out of six parents mentioned their child's weight as a motivator and cue to be more active as a family as well as the need for their children to spend less time indoors engaged in sedentary behaviour playing on computers or watching television.

The TTM and HBM both focus on the intrapersonal level – based on cognitive variables such as knowledge, motivation, intention, perception of threat, outcome expectancy, and social pressure – which shape individual behaviour. However, attempting to effect changes in these factors is rarely as simple as it may appear. Both models acknowledge the importance of the individual in decision-making with respect to health behaviours and are designed to be of direct value in the delivery of desired behavioural change in individuals and populations. In focusing on individuals' health-related perceptions, neither model explicitly address's important social, interpersonal and contextual issues. They also miss important factors that are not intrinsically health-related but play an important role in shaping health behaviours. Both use salient factors of individual perceptions and competing variables such as instigators to readiness and both models embrace self-efficacy as an influence, 'conviction that one can successfully execute the behaviour required to produce the outcomes' (Bandura, 1977).

The differences between the models relate to focus, the relative importance of modifying factors, specificity of behaviour, and outcomes. With the TTM an individual's readiness to change or attempt to change toward healthy behaviours appears to be less complicated and does not take into account personal characteristics or experiences as assumes there is no inherent motivation to progress through the stages of change. Whilst, the HBM focuses on the person's perception of the threat of a health problem and the appraisal of recommended behaviour(s) for preventing or managing the problem. The TTM assumes no single theory can account for all the complexities of behavioural change and is a process that unfolds over time through a sequence of stages and addresses a facet of behaviour change ignored by the HBM, namely that change is a process that occurs over time. The model assumes that stage-matched interventions will primarily enhance self-control. The premise is that the majority of at-risk populations are not prepared for action and will not be served by traditional action-oriented prevention programs. However, change often comes at its own pace – often quickly and in bursts, rather than a consistent rate. It is not unusual for someone to spend years in Pre-contemplation and then progress to Action in a matter of weeks or months. It is, difficult to determine whether behavioural change occurs according to stages or

along a continuum and changes between stages may happen so quickly as to make the stages unimportant.

The TTM assumes there is a common set of change processes that people apply across a broad range of behaviours although common processes have been found to be involved in certain behaviours this is not necessarily consistent with the stages and pros and cons of changing and some behaviours may need fewer change processes. Similarly, within the HBM the relationships between constructs are not well understood and lack clear rules for the combination of variables and the relationships between them. The HBM has no strict guidelines on how the different variables combine to predict behaviours. In addition, the individual determinants are only directly related with healthy behaviour and no indirect or mediating effects exist between the variables. Therefore, this common-sense framework of the HBM simplifies health-related representational processes. However, this weakness can also be viewed as strength, because lack of strict rules of combination offers flexibility that makes the HBM adaptable and applicable to many health behaviour and population groups. Also, its use of simplified health-related constructs makes it easy to implement, apply, and test (Conner, 2010) and is most suitable for addressing problem behaviours that have health consequences (e.g., physical inactivity). Together, the six constructs of the HBM provide a useful framework for designing both short-term and long-term behaviour change strategies.

In terms of using the models for assessment the TMM was useful for understanding the stage of behaviour change and what factors could be targeted to move the parent on to the next stage/s, whilst the HBM was valuable for understanding which factors need influencing to impact on decision-making around family PA. The HBM will be used to inform the main intervention chosen because it recognises the multi-dimensional nature, complexity and probability of health behaviours such as PA among families. The TTM assumes specific processes and principles of change need to be applied at specific stages if progress through the stages is to occur. In

the stage paradigm, the intervention would need to be matched to each individual's stage of change, difficult to administer to a large population group.

In conclusion, using the results from the assessment the HBM indicated parents needed more support to perceive flexibility in completing the recommended PA as a family and more understanding of the health benefits. The aim then will be to develop an initiative to engage families with local green spaces, as this is free and easily accessible in Bromley and to do so by using the assumptions of the HBM. By attempting to include features from the assessment and build on the initiative already available in the borough I chose to explore how the Bromley Walkingtogether programme could be built upon to increase PA in families over the upcoming summer holidays. As coordinator for the programme I am in a good position to develop the programme further. Also, having recently arranged a complimentary trip for volunteer walk leaders to Kew Gardens to thank them for their continued support I had managed to build good relationships with the volunteers who would be integral to the delivery of the intervention.

Intervention

I detailed the issues and concerns I had about families attending the walks and considered how to deal with these (*Appendix B, p.296*). For example, although walking is a very low risk activity, health walks are organised and not just casual activities, those who organise and lead them are regarded in law as having an 'enhanced duty of care' to the people who attend. To ensure the safety of walkers and for best practice I checked all risk assessments had been carried out on routes and walk leaders Criminal Bureau Checks were in place.

A pilot was carried out to test the feasibility of families attending health walks to inform successful implementation of the intervention. Nine parents/carers attended the walk with a total of 13 children ranging from 16 months to 11 years old. One issue that arose straightaway was a parent wanting their child to go on the walk without them defeating the point of the 'family' intervention but also for safety reasons children can only attend when with an adult to supervise them, which the walk leader made clear to the parents. The walk began with a steep road to reach

the nature reserve, one parent decided at this early stage they were too unfit to continue which showed the walks may not be suitable for all levels as I had predicted. The terrain for pushchairs and toddlers was initially difficult due to a muddy area at the start of the walk route. However, normally parents can opt for the pushchair friendly walks. During the walk five walkers became separated from the group for a short time, as the walk leader who was acting as back marker had not kept their position possibly because they were not used to the slower pace of parents with toddlers and had become frustrated. I identified the need to ensure walk leaders are aware the intervention may impact the overall speed of the walk and considered the speed could upset regular walkers. I decided I would need to recruit and train more volunteers to support the walks and allow where necessary walking groups to split into faster and slower walking groups.

From speaking with families during the walk and at the end I found parents were pleasantly surprised to see their children taking much enjoyment in walking and being outdoors. It was a journey of discovery for some parents, whom lived in the area for years and until now had not explored this large nature reserve as one parent said, 'I would not feel safe walking through here without someone else to guide me'. One of the strengths of the walk was it provided a demonstration of how to walk to optimise health benefits through a physical demonstration of behavioural performance i.e. walk leader sets a good, steady walking pace with varied terrain and drew attention to others' performance to elicit comparisons between parents. Parents were asked if they would attend health walks again and if they would recommend them to other families, all parents agreed they would.

Bringing all of these aspects together from the assessment and pilot creates a number of key features to inform the design of the intervention (*Appendix C, p.297*). The title for the scheme was chosen as, 'Take a parent for a walk this summer holiday' designed to be catchy and focus on the upcoming school holidays.

I sent a letter to all primary schools in the borough welcoming them to sign up to the scheme, detailing aims and what it would entail (*Appendix D, p.298*). Schools provide a gateway for targeting parents (especially mothers), and a channel through which interventions can be delivered so I was eager to gain their support of the

scheme and fortunately twelve schools quickly confirmed interest in supporting the initiative.

I developed posters using the Department of Health's Change4life poster development tool. The promotional materials were delivered to schools for publicising (*Appendix E, p.300*) and aimed to guide parents through elements of the HBM: the perceived benefit or efficacy of the target health behaviour and the perceived costs or barrier to performing the target behaviour. The first way theory was applied concerned targeting parents to consider health walks as a way of reducing the risks of lifestyle-related disease and assist the individual to develop an accurate perception of his or her own risk. Parents are more likely to take health-related action (e.g. being physically active) for themselves and their family if they perceive that performing the behaviour will reduce the negative health outcome so information was provided on consequences of the behaviour i.e. highlighting the health benefits of being active (what the potential positive results will be) and the risks of inactivity. Next, was to raise awareness of the benefits of walking as an attractive activity. Walking is a natural and accessible physical activity, something almost everyone can do at any time for free, with no need for special equipment or training, and easy to build into everyday life, benefiting mental health and the social life of the family alongside the physical health benefits. If someone believes that a new behaviour is useful (high perceived benefit), but does not think that s/he is capable of doing it (low self-efficacy), chances are that s/he will not try the new behaviour. The materials supported the preparation process with details of the walks available and who to contact regarding questions. Accordingly, the materials include 'how to' information explaining how, where and when walks take place, their distance, accessibility, and suitability for all PA levels (enhance self-efficacy). Instructions were included on how to perform the behaviour or preparatory behaviours i.e. instruction on suitable clothing, what happens in case of poor weather conditions and where to meet the walk leader (guidance on performing action). Another technique was offering incentives and rewards contingent on successful performance reinforcing the specific target behaviour and acting as a cue to action to spur people to take part. Rewards included medal stickers for children as an immediate reward for attending the walk given out by walk leaders. Details of

the child's school were taken so a certificate could be arranged for each child who attended to be presented at their school. Incentives were also used to motivate repeat attendance and shape regular attendance as each time a walk is attended the child's name is entered into the prize draw to win a pair of junior binoculars. Therefore, the more walks they attended the higher the chance of winning (progressive goal setting).

To try and nurture the school's enthusiasm I provided ideas about how to advertise the scheme and promptly sent promotional materials and example letters to send to parents (*Appendix F, p.301*). I suggested they speak with parents directly if possible to champion the scheme as reinforcement from persons of authority promotes commitment. I arranged a special one-off health walk event (*Appendix G, p.303*) to target one of Bromley's more deprived communities as the HBM postulates cues to action such as an event, can spur people to change their behaviour and this group may need extra support to engage with the scheme. This event included incentives of a free picnic and goody bag containing skipping ropes and Change4Life materials. Parents received a pedometer to support future regulation of their activity levels and to act as a motivational tool.

The walk leaders were made aware of the scheme and sent a pack with the scheme details (*Appendix H, p.303*), promotional materials and told to contact me regarding any queries about the scheme. It was important that I considered their needs and that they were comfortable particularly because being volunteers they should not have to take on more responsibility than they can handle. Therefore, I checked walk leaders had my contact details and the contact details for my team in case of problems and reminded them about incident reporting procedures' including informing me as soon as they can after the incident takes place. I attended training to be able to report incidents formally on the Datix system and arranged a Walk Leader training day to train new walk leaders so there would be more support available for the current walk leaders.

To determine the impact of the scheme, attendance was collected from walk leaders over the summer holiday period. The main indicator of behavioural change was the number of parents and children attending walks and measures of repeat attendance. This shows impact in terms of influencing the different assumptions of the HBM to promote family engagement with health walks. The walk leaders complete a walk register at the beginning of each walk and new walkers are required to fill out an Outdoor Health questionnaire (OHQ), which is part of the national scheme requirements to safeguard walkers. I reiterated to walk leaders that children as well as their parents have to have an OHQ completed. As walk scheme coordinator the walk registers and OHQs are sent to me monthly. This data I stored and kept confidential on a password-protected spreadsheet and in a locked filing system.

Results

In total 42 children and 19 parents attended the walking programme over the summer holidays and although the scheme was predominantly aimed at families the initiative also attracted regular attendance from a local playgroup. The one-off targeted walk attracted another 11 parents and 26 children. Eleven children attended a health walk on more than one occasion and six children attended more than two health walks over the summer.

The results show that the number of families who took part in the Walking for Health programme successfully increased. Also, some families chose to attend more than one walk showing that they enjoyed the walk and/or received benefits from attending. The outcomes collected can be used to determine whether the initiative should continue to be promoted during other school holidays.

Evaluation

Feedback from the eleven walk leaders was mainly positive and there was agreement that families should continue to be encouraged to attend. They enjoyed having new people attend the walks as often they had the same walkers attending each week. They also enjoyed seeing families attend and walk leaders felt good about extending the benefits and joys of health walks to the next generation.

However, a few regular walkers did complain about having to accommodate families by slowing their walking pace or having to keep an eye on children who were not being supervised adequately by parents. Some issues did arise for walk leaders partly because they were not used to families attending walks. Initial problems included a parent not being able to find the walking group as they arrived slightly late and the regular group of walkers were not expecting anyone else to attend. I tried to make them feel supported by attending some of the walks myself, reassuring them they were unlikely to have a sudden rush of families attending and reminding them to contact me if they needed more support. It was important for me to show appreciation to them for their hard work and effort in support of the initiative so I arranged a social event where I also gained feedback from them about the scheme. I made sure to report the results of the scheme back to them via the walking programme newsletter I had set up so they felt an integral part of the success.

One limitation is that there is no longitudinal follow-up of the impact of the intervention. Follow up of families would allow for better understanding of whether parents perceived that performing the behaviour would reduce negative health outcomes enough to continue to the behaviour. To identify changes to the intervention to increase the perceived benefits and perceived costs/barriers, parents who attended the walks could be asked to provide feedback on the intervention regarding why they attended, what they considered the benefits of the walk, any issues with attending the walk and whether they would attend a health walk in the future and why and whether it increased their walking generally.

I had a very positive experience working with local schools, they were keen to promote healthy lifestyles and most schools that signed up required little support from me as they had a good infrastructure in place for promoting activities to parents. However, the children who attended the health walks only came from 7 of the 12 schools so 5 schools who signed up to the scheme had no children attend. Using the assumptions of the HBM families would be encouraged to attend local health walks by influencing their perceived susceptibility, severity, and benefits of this behaviour. However, each school advertised the scheme differently some focused

on advertising the scheme to children, others to the parents, some advertised through their email system and others with posters and leaflets. Certain schools may have played a more active role in promoting the scheme influencing the number of families that attended. On reflection I could have kept in regular contact with the schools after supplying them with the promotional packs to help them advertise effectively, share good practice and possibly correcting any misinformation about the scheme. Also, at the end of the term follow up how the school launched the scheme and whether they felt they had a long enough timeframe to promote the scheme. I felt I gave a positive impression of the work that the local health service is attempting to deliver in the community and hope in future the partnership work between community health and schools will increase. Ideally schools will be able to offer ideas about how best to deliver interventions with their families, as they know them best.

The cost-effectiveness of the scheme was examined however, the walking programme has few costs associated with its running, only administration of the programme and time taken to manage volunteers. The costs were mainly related to the time spent preparing the materials including letters to the schools and preparation of posters. The materials from Change4life including the certificates and medal stickers were free to order and the advertising had minimal costs as schools often came up with their own cost-effective ways to promote the scheme such as via their end of term newsletters. One school asked for support advertising in the form of printing but the only other costs were sending the materials to walk leaders, certificates to the schools and purchasing binoculars for the prize draw winner.

As a professional, I was pleased to be providing a low-cost, positive health initiative based in the community facilitated by volunteers, bringing together young and older members of the community to enjoy their local surroundings. I received positive praise from my colleagues for accomplishments of making positive community partnerships particularly because I was only in the post for a total of six months as maternity cover and had not previously worked in the area.

In conclusion, physical inactivity is a leading risk factor for mortality and chronic disease and with rising rates of inactivity among adults and children there is a need for early intervention to increase levels of PA participation. As long as an area is running a walking programme then interventions can be targeted to engage families in health walks, successfully and at low-cost by using this scheme and having the support of local schools. However, there is a danger in assuming that changing behaviour is 'obvious' – it is likely even seemingly simple plans need careful formulation before they can exert strong effects particularly for those from disadvantaged areas of the community.

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SECTION C SYSTEMATIC REVIEW

Health Beliefs of UK South Asian Related to Lifestyle Diseases: A Review of Qualitative Literature

Abstract

Objective: To review available qualitative evidence in the literature for health beliefs and perceptions specific to UK South Asian adults. Exploring available insight into the social and cultural constructs underlying perceptions related to health behaviours and lifestyle-related diseases.

Methods: A search of central databases and ethnic minority research groups was augmented by hand searching of reference lists. For included studies, quality was assessed using a predetermined checklist followed by metaethnography to synthesis the findings, using both reciprocal translation and line-of-argument synthesis to look at factors impacting uptake of health behaviours.

Results: A total of 10 papers varying in design and of good quality were included in the review. Cultural and social norms strongly influenced physical activity incidence and motivation as well as the ability to engage in healthy eating practices.

Conclusions: These qualitative studies provide insight into approaches to health among UK South Asians in view of their social and cultural norms. Acknowledgement of their approach to lifestyle behaviours may assist acceptability of interventions and delivery of lifestyle advice by health professionals.

Introduction

People of South Asian¹ origin in the UK manifest obesity-related diseases more frequently and earlier than other groups (Bhardwaj, Khurana, Gulati, Shah, & Vikram, 2008, Misra, Khurana, Isharwal, & Bhardwaj, 2009) at lower levels of body mass index to European populations (Joshi, Islam, Pais et al. 2007). They are at considerably higher risk of diabetes than the general UK population (Health survey for England, 2001). Genetic factors are important, however the increased incidence

¹*South Asian:* people living in the United Kingdom (UK) with ancestral origins from Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka.

of these diseases is strongly associated with rising obesity in this group (Duncan, Woodfield, Al-Nakeeb & Nevill, 2008) where lifestyle changes can reduce risk factors such as a sedentary lifestyle, diet, smoking, stress and depression.

In the UK, South Asians are the largest ethnic minority who now comprise the majority ethnic group in several urban locations from the latest UK census. Despite this there remains little evidence of successful interventions among South Asian groups and theories of health behaviour specify only a limited subset of cognitive determinants that are assumed to be most proximal to the general population's behaviour. Health research has focused on the differential occurrence rate of specific disease in ethnic minority groups in relation to indigenous UK populations. Ethnicity is not just a question of language and research exploring cultural differences, including how experiences and health beliefs reflect health behaviours (an action taken by a person to maintain, attain, or regain good health and to prevent illness), is still limited among people of South Asian descent. Given the elevated risk of lifestyle-related disease in South Asian communities, there is a need to identify beliefs that may contribute to health risks and current health behaviours exploring psychosocial risk factors for ill-health (e.g. socio-economic status, diet, family conflict, attitudes/beliefs, health-related behaviours and work patterns). NICE guidelines (National Institute for Health and Clinical Excellence) recommend advice on lifestyle change is tailored for different groups particularly minority groups as their uptake of health information is lower than other groups and under-researched.

There is some consensus that addressing deep-rooted influences on health behaviours in 'at-risk' groups, including cultural influences is important (McAllister & Farquhar, 1992; Pasick, 1996; Resnicow, 1999). Culture is a complex interaction of a multitude of factors that give people an ethnic belonging and also impacts on their lifestyle and predisposition to chronic disease. For intervention to be successful on meeting the needs of the target community, providers need to be informed by an understanding of a group's lifestyles, attitudes and beliefs. A more complete explanation of particular health behaviours is necessary by extending theories to include other relevant determinants, investigation of these variables by qualitative research provides insights into factors that may be mediators of motivation to change

behaviour such as cultural and social norms. Qualitative research can be used to inform strategy for the promotion of healthy lifestyles and recognised as increasingly important in developing the evidence base for public health (Thomas & Nelson, 1996). These methodologies are especially appropriate for understanding individuals' and groups' subjective experience whilst, being sensitive to the contextual, social, economic, cultural factors which influence health beliefs and behaviours. These are difficult to access using quantitative approaches as such methods do not give us an adequate understanding of the factors involved. The inductive nature of qualitative research allows for theory to emerge from the lived experiences of research participants rather than the pre-determined hypotheses testing of quantitative approaches.

Objective

A review of UK literature was carried out to identify available evidence on the perceptions around lifestyle disease and health behaviours among UK South Asians. Investigating what is known about awareness, knowledge, perceptions and misconceptions about living a healthy lifestyle for UK South Asians enhancing our understanding of social and cultural constructs among this group. Further, to identify key themes emerging from research, helping guide intervention programmes and future research.

Selection of Articles

Articles for inclusion were scientific articles written in English, published between 1975 and 2011 (qualitative minority research not presented prior) and studies exploring health behaviours among UK South Asians aiming to capture the nature of their behaviours and lifestyle choices(see *Table 1* for criteria).

Three electronic strategies were used (thesaurus terms, free-text terms and broad-based terms) for searching across bibliographic databases. A wide range of databases (i.e. Medline, Web of Knowledge, Cochrane Library, PsyINFO, EMBASE) and public health websites (i.e. WHO, DH, HPA) including government websites; NHS Scotland Library, Health Technology Assessments (HTA), National Institute of Health and Clinical Excellence (NICE) were searched. To ensure inclusion of papers that may not be submitted to peer review additional websites searched include

Diabetes UK; NHS Evidence specialist collection for Diabetes; NHS Evidence specialist collection for Ethnicity and Health. Relevant references from published literature were followed up and all potentially relevant articles and titles and abstracts of articles were screened and full-text copies of all potentially relevant articles were reviewed.

As the terms South Asian, health beliefs and health behaviour have many synonyms, these terms were not always present in the research objective/s. Examples of search terms include the following in *Table 2*. Where possible the appropriate indexing term was used for each database. The search results are shown in *Diagram 1*.

Table 1. *Inclusion criteria*

	<i>Studies which met the following criteria were included:</i>
1.	Primary research, of which the sole or major focus is to explore health behaviours, beliefs and perceptions.
2.	The sole or major participant group is UK South Asians adults defined as people of South Asian origin (people with ancestral origins from Pakistan, India, Bangladesh and Sri Lanka) living in the UK of any age.
3.	The study is conducted using, solely or as a major part, a qualitative methodology

Table 2: *Search Terms*

Criteria topics	Search Terms
Ethnicity	South Asian, Asian
Lifestyle related health problems	Type II Diabetes, obesity, CHD
Dietary choices	Diet, dietary, food
Physical activity (willingness)	Exercise, activity, fitness
Approach to using healthcare	Accessing healthcare, adherence, help-seeking behaviour
Accessing local leisure facilities	Exercise, activity, fitness
Formation & maintenance of health behaviours	Adherence, motivation

Review question

'Investigating what is known about awareness, knowledge, beliefs, perceptions and misunderstanding about living a healthy lifestyle for South Asians'

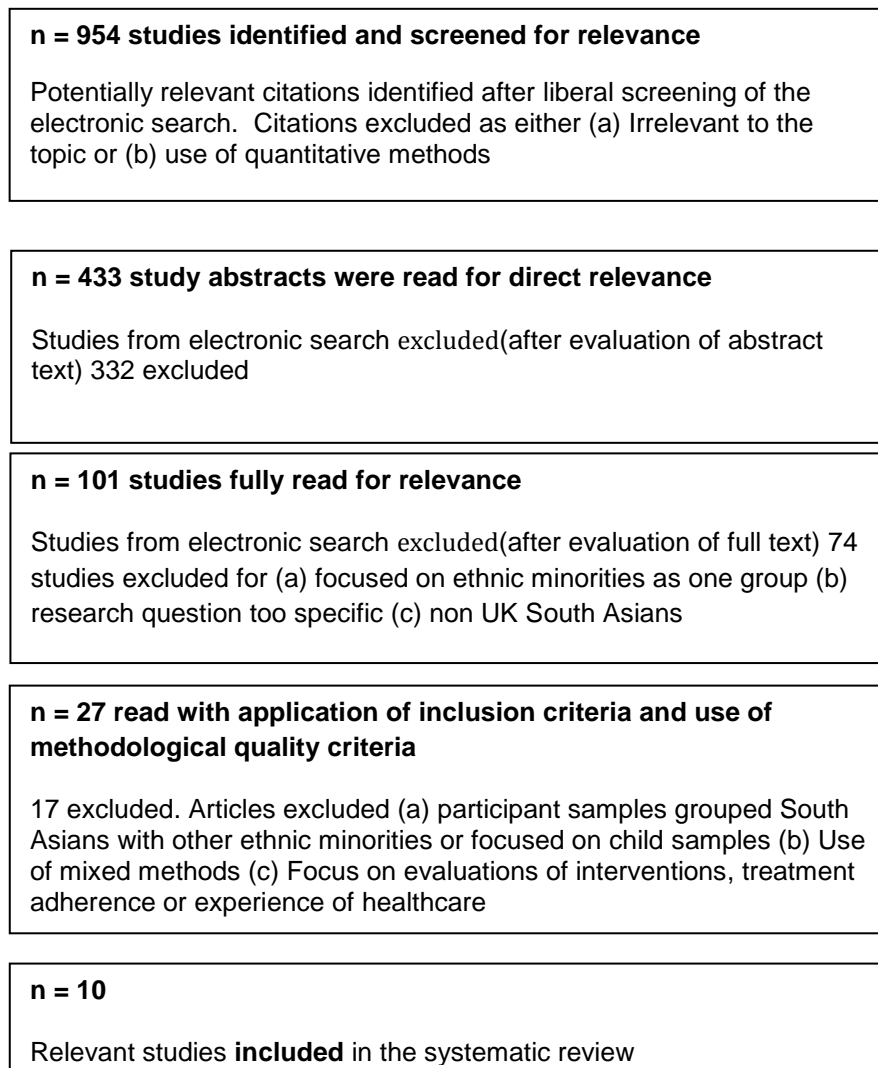


Diagram 1. *Flow chart of search results*

Quality appraisal

The criteria outlined in *Table 3*. is a checklist established by Munro et al., (2007) based on common elements from existing criteria for qualitative study quality assessment (Dixon-Woods, 2007, Mays & Pope, 2000, Malterud, 2001, Rowan, Huston., 1997 & Critical Appraisal Skills Programme, 2002) and has been used to guide the review and evaluation of the elements of each particular study, given its context and purpose. Evaluating study quality allows us to describe the range of quality across included studies. Articles were examined for methodological quality

showing all clearly defined their purpose giving adequate descriptions of sampling and justification for data collection. However, details for sample validation and assessment of generalisability were less clear with limited evidence of triangulation. Various qualitative methodologies were used with few justifying their reasoning for the chosen method and detail of analysis. All studies clearly identified experiences inherent among this group, with interpretations that could serve to further the understanding of the participant's experience and in view of these criteria all ten studies were included due to evidence of good rigour.

Table 3. *Munro et al., (2007)*

Quality Criterion	Met criterion	Did not meet criterion	Unclear
Is this study qualitative research?	10		
Are the research questions clearly stated?	9		1
Is the qualitative approach clearly justified?	4	4	2
Is the approach appropriate for the research question?	9		1
Is the study context clearly described?	8		2
Is the role of the researcher clearly described?	7	2	1
Is the sampling method clearly described?	7		1
Is the sampling strategy appropriate for the research question?	7		3
Is the method of data collection clearly described?	8		2
Is the data collection method appropriate to the research question?	10		
Is the method of analysis clearly described?	5	1	4
Is the analysis appropriate for the research question?	7		3
Are the claims made supported by sufficient evidence?	10		

Method of Synthesis

The findings, context, and analysis of the ten included studies were used as data in

the present study. A meta-ethnographic approach described by Noblit and Hare (1988) the steps of which are (outlined in *Figure 2*) taken to synthesise themes and patterns identified by reading and rereading the included studies. This systematic approach translates ideas, concepts, and metaphors across different studies and is increasingly seen as a favourable approach to synthesising qualitative health research.

Once themes were identified an attempt was then made to translate these into each other. In this process, primary themes or first-order constructs are understood as reflecting participants' understandings, as reported in the included studies (usually found in the results section of an article). Secondary themes or second order constructs are understood as interpretations of participants' understandings made by authors of these studies (and usually found in the discussion and conclusion section of an article).

Translation involves the comparison of themes across papers and an attempt to "match" themes from one paper with themes from another, ensuring that a key theme captures similar themes from different papers from the reciprocal translation a table was constructed showing each theme. When synthesising translations to develop an overarching framework (or third-order interpretation), translated themes into a hypotheses, in a "line-of argument" synthesis. Line-of-argument syntheses create new models, theories, or understanding rather than a description of the synthesised papers.

Analysis

The findings, context, and analysis of the ten included studies were used as data in the present study. This review incorporates the concepts identified in the primary studies into a more subsuming theoretical structure. This structure may include concepts which were not found in the original studies but which help to characterise the data as a whole and take into account different settings and sub-groups. The analysis proceeded according to the following steps:

Steps of analysis

-
1. Read articles several times
 2. Create grid of methods, samples, findings, and context, (*see Table 4*)
 3. Create grid of key concepts and themes, (*see Table 5*)
 4. Explore commonalities, dissonance, and gaps with consideration of the context of the studies.
 5. Develop review of results and discussion
-

Methodological Reflections

Included articles had to present an acceptable and justified qualitative research method (based on the criteria in *table 3*) but few provided enough detail to judge this accurately and a variety of methods and paradigms were presented. However, it was accepted that the main interest of the studies was of the experience that was being explicated. Also, synthesising studies from a variety of contexts presents challenge, but these studies provided an opportunity in the synthesis to explore the differences between the contexts, if these existed.

This review incorporates the concepts identified in the primary studies into a more subsuming theoretical structure. This structure may include concepts which were not found in the original studies but which help to characterise the data as a whole and take into account different settings and sub-groups. All reported data was recognised as the product of author interpretation. Although the foci of the studies were not all directly comparable, a number of recurring first- and second-order constructs were identified.

Figure 2. *Meta-ethnography process, (Noblit & Hare, 1988)*

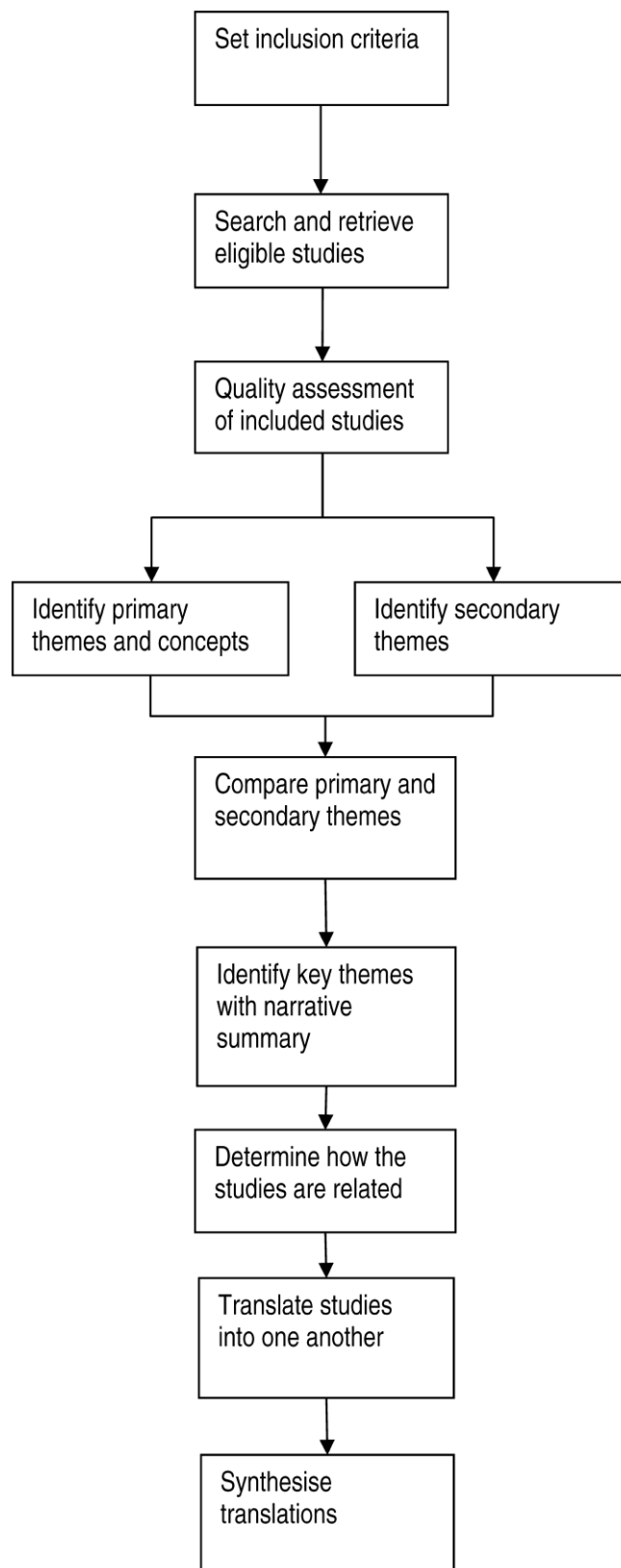


Table 4. *Study characteristics*

Lead author, year of publication	Research question	Participant sample	Method of data collection	Analytic strategies	Themes from results
(1) Choudhury et al. 2009	Examine the understanding & beliefs of people with diabetes in terms of their condition, its causes, prevention & management	n = 14 4 male, 10 female, aged 26-67yrs: Bangladeshi All with Type 2 diabetes	Structured interviews	Data transcribed & analysed, coded by two independent researchers using word & excel following the preset questions	<ul style="list-style-type: none"> • Cause of diabetes • Preventing diabetes • Diabetes diagnosis • Management of diabetes • Information from healthcare professionals • Physical activity • Information from family/friends and use of traditional medication • Diabetes education
(2) Darr et al. 2008	To compare illness beliefs of South Asian & European patients with CHD about causal attributions & lifestyle change	n=65 Pakistani & Indian : 26 males, 19 females, aged 40-82 European: 10 males, 10 females, aged 42-83 All with CHD	Interviews	Framework approach analysis (Richie & Spencer, 1994)	<p>Causal attributions & lifestyle change</p> <ul style="list-style-type: none"> • Family history • The role of fate • Stress • Tobacco smoking • Physical activity & exercise • Dietary intake • Stress management
(3) Farooqi	To identify key issues relating	n=44 24 male, 20	Focus groups	Thematic/content	<ul style="list-style-type: none"> • Diet • Exercise

et al. 2000	to knowledge of & attitudes to lifestyle risk factors for CHD	female South Asians aged 40+ yrs		analysis	<ul style="list-style-type: none"> • Smoking • Alcohol • Accessibility of health services • Stress
(4) Grace et al. 2008	To understand lay beliefs & attitudes, religious teachings & professional perceptions in relation to diabetes prevention	n=137 54 males, 83 females; 80 Bangladeshi lay people (37 females, 43 males, mean age 35), 29 Islamic religious leaders, 28 health professionals	Focus groups, 3 sequential phases (vignettes)	Thematic analysis with use of NVIVO, multilevel theoretical framework, critical fiction technique	<ul style="list-style-type: none"> • Lay understanding of diabetes • Living a 'healthy' life • Responsibility for diabetes prevention • Fatalism • Social roles and expectations • Structural & practical constraints to healthy lifestyle choices • Health literacy & English fluency
(5) Greenhalgh et al. 1998	To explore the experiences of diabetes & underlying attitudes & belief systems which drive that behaviour	n = 50 40 Bangladeshi (17 males, 23 females), 8 white British, 2 Afro-Caribbean aged 21-80 All with diabetes not distinguish which type	Semi-structured interviews &	Analysed using NUDIST software	<ul style="list-style-type: none"> • Body concepts • Origin & nature of diabetes • Impact of diabetes • Diet and nutrition • Smoking • Concepts of balance • Exercise • Professional roles • Diabetic monitoring

<p>(6) Lawton et al. 2008</p>	<p>To look at food & eating practices from the perspectives of those with type 2 diabetes, barriers & facilitators to dietary change, social & cultural factors informing their accounts</p>	<p>n = 32 15 male, 17 female; aged 33-71, Pakistani & Indian All with type 2 diabetes</p>	<p>Topic-guided interview</p>	<p>Constant comparative method of analysis (Strauss & Corbin 1990) in line with Grounded theory approach. QSR*NUDIST used</p>	<ul style="list-style-type: none"> • Information from healthcare professionals • Perceptions of SA foods: bad for health; good for self • Settlement, sharing & commensality • Strategies for passing: cutting out or cutting down
<p>Lead author, year of publication</p>	<p>Research question</p>	<p>Participant sample</p>	<p>Method of data collection</p>	<p>Analytic strategies</p>	<p>Themes from results</p>
<p>(7) Lawton et al. 2006</p>	<p>Patients' perceptions and experiences of undertaking physical activity as part of their diabetes care</p>	<p>n = 32 15 male, 17 female; Pakistani and Indian patients aged 33-71 All with type 2 diabetes</p>	<p>Interviews informed by a topic guide</p>	<p>Constant comparative method of analysis (Strauss & Corbin 1990) in line with Grounded theory approach. QSR*NUDIST used</p>	<p>Roles, norms & responsibilities:</p> <ul style="list-style-type: none"> • Lack of time: obligations to others • Fear and shame <p>External constraints</p> <ul style="list-style-type: none"> • Lack of culturally sensitive facilities • Climatic conditions <p>Perceptions & experiences of disease</p> <ul style="list-style-type: none"> • Co-morbidities • Accounts of causation; perceptions of future health • Diabetes triggers

					<p>irreversible decline</p> <ul style="list-style-type: none"> Physical activity can engender anxiety <p>Activities & active respondents</p> <ul style="list-style-type: none"> Short-term goals
<p>(8) Ludwig et al. 2011</p>	<p>Explored health perceptions, diet & the social construction of obesity & how this relates to the initiation & maintenance of a healthier diet in UK Pakistani women</p>	<p>N = 55 Pakistani women aged 23-80</p>	<p>Semi-structured interviews use of fictional vignettes & body shape images</p>	<p>Analysis using phenomenological & sociological approaches</p>	<p>Phenomenological analysis</p> <ul style="list-style-type: none"> Diabetes symptoms Reasons for overweight Health action Motivation to change <p>Sociological analysis</p> <ul style="list-style-type: none"> Identity deconstruction: Muslim, Pakistani, British Family <p>Emergent themes</p> <ul style="list-style-type: none"> Risk awareness Urban v. Rural background Climate Food traditions/expectations English v. Pakistani food Obesity & health
<p>(9) Sriskant harajah et al. 2006</p>	<p>To explore the influences on, & attitudes towards, physical activity among South Asian women with CHD & diabetes to inform secondary</p>	<p>n = 15 (all female, aged 26-70) South Asian All with either CHD and/or non-insulin-dependent diabetes</p>	<p>Semi-structured interviews</p>	<p>Transcribed & analysis informed by Grounded theory</p>	<ul style="list-style-type: none"> Perceived harm threshold limits activity Insufficient guidance from health professionals Weight loss, maintaining independence and socialising perceived as main benefits of exercising Some understanding of benefit of exercise

	prevention strategies				<ul style="list-style-type: none"> • Exercise beyond daily work seen as 'selfish' activity • Discomfort with exercising in public • Constrained by not being able to speak English
(10) Stone et al. 2005	To explore the experience & attitudes of primary care patients with diabetes living in a UK community with particular reference to South Asians & patient empowerment	n = 20 (9 males, 11 females; aged 33-80; 15 South Asians, 5 Caucasian) South Asians All with diabetes	Semi-structured interviews	Transcribed & emerging themes informed subsequent interviews, use of Thematic analysis Framework charting	<ul style="list-style-type: none"> • The patient experience: attitudes to diagnosis • The patient experience: difficulties faced • Types of support: emotional support • Types of support: empowerment through knowledge • Attitudes to self-management • Barriers to knowledge acquisition

Study characteristics

Although inclusion of evidence was not restricted by study type other than use of qualitative methods, there was a focus on study designs that elicited views around health behaviour rather than views on treatment programmes and health services. The studies employed methodologies that range from case studies to semi-structured interviews, and in-depth interviews to focus group discussions. Taping with transcription of data was the most common method used to demonstrate credibility. Ethnically matched interviewers, peer debriefing and multiple researchers were also common. All the studies explored in some manner health beliefs and perceptions associated with lifestyle. Of these, three were based on thematic analysis, one used framework analysis, a form of critical theory of phenomenological

and sociological approaches and four stated that they used grounded theory. Qualitative data analysis software packages were used by four studies but only one used this as their sole method of analysis. The studies were all conducted in England and the combined sample of participants across studies included 377 (153 males, 224 females) South Asian adult participants with a wide age bracket for all studies with participants aged from 21-82 years of age. The populations investigated were South Asian or specifically Indian, Pakistani or Bangladeshi groups. Three studies had control/comparative groups of European, White British or Afro-Caribbean. Seven studies looked at those with either Type I or Type II Diabetes or CHD and three looked at 'healthy' population samples.

Results

The studies investigated a variety of research questions exploring elements of health beliefs and behaviours specific to this group. The studies' research questions can be separated into the following groups:

- Knowledge, understanding and beliefs of lifestyle related disease (Type II diabetes or CHD) (6)
- Dietary intake and physical activity related to diabetes care (2)
- Health perceptions and the role of diet (1)
- Barriers and attitudes to physical activity (1)

Different studies used methodological and epistemological approaches to analyse data however a number of consistent findings emerged and a broad range of contributors were identified regarding the uptake of 'healthy' behaviours from a South Asian perspective. This review looks at the evidence, focusing on the identified main themes (see *Table 5*). The results have been grouped under two categories to be discussed further within this review: Understanding health and disease, and barriers to engaging in health behaviours.

Table 5. *Identified key themes and sub-themes*

	Study									
Themes and sub-themes	1	2	3	4	5	6	7	8	9	10

Beliefs about origins/cause of CHD or Type II diabetes			X		X		X			X
Fatalist approaches to health	X		X					X		
The role of diet in preventing/managing disease	X	X	X		X					X
Relationship between physical activity and health		X					X		X	
Role of the individual in health/disease management	X	X		X	X	X	X			X
Socio-cultural influence on physical activity		X		X	X		X	X	X	
Socio-cultural influence on food & eating practices		X		X	X	X		X		X
Perceptions of 'a healthy weight' & a healthy body				X	X			X	X	
Prioritising individual health vs. prioritising others						X		X	X	

1. Understanding of health & disease

1.1 Lack of personal risk

Difficulty identifying aspects of lifestyle that contribute to the development of lifestyle-related disease (Darr, Astin & Atkin, 2008, Farooqi, Nagra, Edgar & Khunti, 2000) with diabetes suggested as causing obesity (Ludwig, Cox & Ellahi, 2011). The majority of studies found South Asian participants lacked understanding of the relationship between lifestyle and disease. Those diagnosed with a lifestyle-related condition were often unconvinced of the impact their lifestyle choices had on health. Personal disease risk and cause were often instead attributed to a range of external influences commonly stress, heredity, pollution, too much sugar or fried food in their diet as influential factors on health. A shared assertion by those with Diabetes or CHD was not being sure or understanding the root cause of their disease (Choudhury, Brophy & Williams, 2009, Farooqi et al., 2000, Ludwig et al., 2011). Indeed, very few related their own lifestyle choices and behaviours in any direct and obvious way. Lawton, Ahmad, Hanna, Douglas, & Hallowell, (2006) reported 1st generation participants regarded the development of diabetes almost universally to factors outside their control suggesting it was the will of Allah/God, genetics or a

change in climate and environment brought about by their migration to the UK. The mention of an imbalance of bodily fluids (based on humoral medicine) (Greenhalgh, Helman & Chowdury, 1998) and imbalances of sugar in their blood (Choudhury et al., 2009) were reasons given for their condition.

Many were able to recall and quote lifestyle advice from health professionals but the relative importance of these risk factors did not appear to influence beliefs or translate to behaviour change. For example, Males understood smoking to be linked with disease but few were convinced this would impact on their health (Farooqi, Nagra, Edgar & Khunti, 2000). Increased risk of disease was often not linked with likely risk factors i.e. being overweight. Whilst, stress was more commonly cited as cause of disease development (Greenhalgh et al., 1998, Ludwig et al., 2011). Where weight loss had been advised, this advice was confounded by beliefs that carrying extra weight was not an indication of being unhealthy or a health problem but quite the opposite indicating good health, weight or status and reduced incentive to engage in weight loss behaviour (Greenhalgh et al., 1998, Ludwig et al., 2011). Similarly, physical activity was not readily identified as a risk factor although low impact activity such as walking was related to general well-being. Physical activity was considered as negatively impacting health or exacerbating illness by increasing physical weakness (Lawton, Ahmad, Hanna, Douglas, & Hallowell, 2006, Sriskantharajah & Kai, 2006, Darr et al. 2008). Uncertainty over the type of exercise needed and duration for impact appeared a common barrier to forming intentions and across studies more clarity on the risk factors and preventive actions were desired.

Personal and familial risks of diabetes and CHD were observed without concern and few linked such diseases specifically with risks related to their ethnicity. One study, (Grace, Begum, Subhani, Kopelman & Greenhalgh, 2008) did however find knowledge of risk factors for developing Type II diabetes high (Bangladeshi sample) and this awareness was primarily described due to experiences of diabetes by relatives or friends. When discussing prevention of diabetes participants believed fear of the devastating impact of diabetes would motivate preventive action across the Bangladeshi community. Others, felt diabetes was so widespread in their community and (implicitly) something not to be too concerned about. Often, it was

not until diagnosis of CHD or diabetes that signalled the need to adopt a healthier lifestyle (Farooqi et al., 2000, Grace et al., 2008). Some described how their own experience of developing disease complications, that of similarly affected relatives and friends, or fear of needing extensive treatment (such as insulin injections) had encouraged them to engage in exercise. However, these perceptions also acted as a de-motivational effect as far as the uptake or maintenance of physical activity once diagnosed with diabetes (Sriskantharajah & Kai, 2006). Lifestyle changes were often focused on diet rather than physical activity, which researchers suggested was due to their focus of diabetes and CHD on imbalances, sugar or fat intake all related to diet rather than physical activity.

Physical degeneration and weakness were viewed as virtually synonymous and an inevitable consequence of ageing with the belief that little, if anything can be done to reverse or delay this process (Greenhalgh et al., 1998, Lawton et al., 2006). For some the perception of ill health being due to age was borne out of their exposure to the high number of family and fellow community members suffering from numerous health problems (Lawton et al., 2006).

1.2 Fatalistic beliefs

A belief in control over individual health status was contradictory as accounts of understanding that food and activity choices influence health. However, many reasoned an individual's role in their health was externally influenced if not controlled inducing a more passive approach to health.

'We have much fear of this disease, once this disease is developed, there will be no way to save yourself'. (Sriskantharajah & Kai, 2006).

Grace et al. (2008) compared South Asians with White populations and found South Asians more likely to externalise responsibility of diabetes, reporting general life circumstances as central to cause in comparison with internalised responsibility by White groups. However, both groups cited beliefs that they had been fated to suffer CHD or diabetes (Darr et al., 2008, Farooqi et al., 2000). This demonstrates beliefs around disease occurrence may be common to people with these conditions however, fatalism did appear stimulated by South Asian religious beliefs (Grace et

al., 2008). Fatalistic views have often been associated with South Asian cultural and religious beliefs, and many of these studies found evident expressions that ill health was fate. Religious fatalism was often suggested as just among older relatives rather than the participants themselves and attributing illness to events or agents outside of the body rather than to primary failure of an organ within it was evident among older generations (Greenhalgh et al., 1998). However, even those with family history of diabetes and those with understanding of their role in health status often mentioned the idea of God, and not the individual as being ultimately responsible for health (Darr et al. 2008, Greenhalgh et al., 1998). Fatalistic views were reinforced by beliefs that health, illness and death are pre-ordained by Allah/God but family experience of disease and experiences by relatives were also significant. Farooqi et al., (2000) reported health conditions were often viewed as the will of God but the individual still had a responsibility to look after their health. Illness could be described as an indication from God that they had not looked after their health and a sign that changes needed to be made to their lifestyle. Ludwig et al., (2011) found female participants expressed a strong sense of fatalism with regard to personal health risks and weight gain related to the ageing process described as normal and inevitable. Causal attributions were influenced by fatalist approaches to health and the uptake of health behaviours but not always defined by cultural or religious beliefs and those with a strong family history of diabetes tended to view their diagnosis as inevitable and accepted it with resignation (Farooqi et al., 2000) feeling like there was nothing that they could have done to avoid the onset of their condition (Darr et al., 2008). Individuals with diabetes and CHD expressed great anxiety about their health and some experienced depression related to their lack of understanding over why they were afflicted. A lack of individual control over health was highly related to feelings of anxiety and hopelessness regarding their condition. (Stone, Pound, Pancholi, Farooqi &Khunti, 2005, Farooqi et al., 2000).

1.3 Sources of information and advice

A view prevalent among the older generations was that management of health should be left to qualified health professionals. Specific barriers such as language difficulties and multiple health problems were described as reasons for their lack of ability/interest in understanding their own condition. A number of participants felt it

impertinent to ask questions of their healthcare professional and to do 'whatever the doctor tells' (Greenhalgh et al., 1998, Choudhury et al., 2009). Doctors were viewed as busy, authoritative and knowledgeable, rarely making mistakes and with full understanding of the individual's condition. The use of a family member as translator was necessary for some and they asked fewer questions so as not to appear difficult. Instead, reference to family networks and history of diabetes among family or friends (Stone et al., 2005) created the main informational sources, which reduced their need to seek additional support. Younger participants expressed a high value on education and learning with interest in increasing their control over their health (Stone et al., 2005). However, this was not necessarily matched by action as few attended organised educational initiatives or support groups citing excuses relating to lack of time. Health information and advice was gathered for the most part from health professionals, peers and elders and information was viewed as accessible and helpful. Word of mouth was the primary source for delivery and receipt of information (Choudhury et al., 2009, Sriskantharajah & Kai, 2006) playing an important role in defining the information received.

Health professionals were reported to be sources of advice and motivation to make lifestyle changes however difficulties arose when attempting to use advice. Choudhury et al. (2009) found South Asian women were strongly, though passively, influenced by their doctor's recommendations. It is well documented that knowledge alone does not always translate to behaviour change and more so for the women influenced by strong family networks prioritising adherence to cultural and social norms. An ability to recall guidance received from doctors was apparent (Greenhalgh et al., 1998, Choudhury et al., 2009) but cultural norms acted as a barrier when attempts were made to change behaviour. Importantly, information from non-professionals (peers/elder) appeared more influential. Information from peers/elders was viewed with high regard and for those who had a family history of dealing with diabetes; family was described as a major source of information. This information was more relevant to their cultural norms increasing likelihood of individuals internalising the information. Uncertainty about information from health professionals particularly when alternate advice was received from peers/elders. Alternate advice included understanding the main cause of diabetes as being high dietary sugar intake and beliefs that Kerala and other 'bitter' foods prevent and help manage

diabetes instead of considering the larger modifications to their lifestyle suggested by health professionals (Choudhury et al., 2009, Greenhalgh et al., 1998).

One study of South Asian women (Sriskantharajah & Kai, 2006) found in contrast to receiving considerable nutritional advice from Dieticians, they typically received cursory and general exhortations, 'to just do more exercise' as part of other health consultations in primary and secondary care. Rather, what they sought was more detailed and specific guidance about appropriate exercise.

'He (health professional) just says...just do more exercise that's it...the doctors and the health advisors they don't give you the proper information. They don't push you....it would help....if (we) had people telling (us) how to do the exercise.'

(Sriskantharajah & Kai, 2006)

The need to prioritise engagement in health behaviours such as physical activity or dietary modification was clearly reduced by beliefs common among this group. Advice and support from health professionals did not appear to have the same impact as peers/elders on their enduring health beliefs and behaviours.

2. Barriers to engaging in health behaviours

Even though many expressed the need for lifestyle changes to benefit their health, intentions were frequently not made clear and transforms into behaviour change. Similar barriers to behaviour change arose across studies and a disproportionate amount of barriers to leading a healthier lifestyle were described. The idea of preventing disease by a healthy lifestyle was not a goal strived for, highly regarded or prioritised. Many participants exhibited low perceived behavioural control (Ajzen, 1991) in regard to their dietary choices and physical activity behaviour. Perceived behavioural control is an individual's perceived ease or difficulty of performing a particular behaviour.

2.1 *Being active*

There was no concept or goal of being physically fit or gaining enjoyment from exercise and this relates to distinct beliefs and behaviours among this group. Basic awareness of physical activity being important for health but a clear lack of putting

this into practice (Lawton et al., 2006). Walking was the most common form of physical activity with few attending any organised forms of activity. Cultural and social expectations, time constraints and health problems appeared to reduce the likelihood of physical activity.

There was an absence of exercise culture within this group together with a distinctive dislike for most forms of exercise offered locally such as gyms (Sriskantharajah & Kai, 2007, Lawton et al., 2006). What was accepted as being healthy (being physically active) was seen as less important than social norms like group socialising, the religious requirement for modesty, and the cultural rejection of 'sporting' identity or dress (Grace et al., 2008) and therefore motivation to be active through specific exercise was near non-existent. The role of cultural beliefs and traditions were displayed as important in leisure time choices, influencing motivation to engage in activities such as joining a sports team or using local leisure facilities as traditionally sports and games are not pursued by adults (Lawton et al., 2006). Environmental barriers may also have influence on participation in physical activity as participants often lived in urban city environments why. Lawton et al., (2006) found dislike of outdoor activities, bad weather and a high usage of cars even for short journeys to the shops meant that indoor activities were the most appealing. However, two studies found cultural factors and a lack of awareness of the benefits of physical activity the biggest impact on behaviour (Sriskantharajah & Kai, 2007, Lawton et al., 2006).

The notion of 'exercise' for oneself-beyond daily work-was perceived by some as a selfish activity, or given little priority as expectations by family and community were more important especially by women (Ludwig et al., 2011, Sriskantharajah & Kai, 2006) who prioritised family expectations and needs. The notion of family first was a key influencer on time restricting opportunities for individual interests and activities. For women, it remained a function relegated to normal daily duties rather than any enjoyment or added provision of time to focus on being physically active. Many made reference to activity needing to be socially rewarding with the appeal being of group rather than individual activity. Exercise demanded justification or sanction to occupy one's time and resources in this way.

The emphasis was on the cultural importance of being active day to day, rather than the 'western' concept of organised exercise. Physical activity appeared culturally irrelevant in the case of Bangladeshi groups the word physical activity or exercise was noted (Greenhalgh et al., 1998) as not featuring within their native dialect giving us understanding of why it is viewed as an informal activity predominantly involving walking only. Some reflected on their religious beliefs encouraging and instructing them to look after their health by keeping physically fit but less formally and in less obvious exercise was discussed positively such as walking and carrying out prayers (Namaz) as a worthy and health giving form of exercise (Greenhalgh et al., 1998, Grace et al., 2008).

As a consequence of leading very busy lives men and women pointed out this was evidence for them being physically active already as part of their daily duties. Lack of time was a key barrier to physical activity, yet being active daily was viewed as a strong cultural obligation. For men the culture of a strong work ethic meant they felt obligated to dedicate their time to providing for their family working very long or antisocial hours often in shops or restaurants (Lawton et al., 2006). Women felt they were by definition, engaging appropriately in physical activity from care-giving, house-keeping and work day activities so extra time for specific exercise (i.e. aerobics class) was not acceptable as family duties were their priority (Sriskantharajah & Kai, 2007).

Family concern was described as a motivator to be physically active and as weight gain may compromise the woman's role as family carer or the man's role of the wage earner reference to this rather than individual health gains (Ludwig et al., 2010) Women expressed that breathlessness, increased heart rate and sweating (normal by products of physical exertion) as something they wished to avoid (Ludwig et al., 2011, & Sriskantharajah & Kai, 2006). Exercise also lacked cultural acceptance in its obvious form of sweating and vigorous movement. Women described principal motivations to walking were relaxation and refreshment from getting out of doors, a change of scenery and in particular as a form of socialising with other women (Sriskantharajah & Kai, 2006).

A couple of studies with women only samples delved deeper...Women cited a variety of externally imposed barriers of which they had little or no control over like adhering to cultural expectations that women should walk slowly in public not being seen to hurry (Lawton et al., 2006). Restrictions on women leaving the home (especially to enter mixed-sex settings) and to remain within the home was a traditional social norm, this norm conflicted with efforts at lifestyle change. A few pointed to once a woman is married, she is expected to stay indoors, attending to domestic chores and responsibilities,

‘Women cannot go out...You have to cook and provide meals at the right time, so because of that there is a restriction. He (husband) goes out when he feels like it, but it is different for women.’ (Lawton et al., 2006)

Further barriers for women included language, racial harassment, dress codes, modesty and inappropriate facilities (Grace et al., 2008, Lawton et al., 2006). Gender separated sessions were described as preferable, however many had never attempted to attend these sessions even though they had been recommended to them (Ludwig, 2011, Sriskantharajah & Kai, 2006). Suggestions to increase physical activity included activities organised by members of their own community as this would ensure a culturally appropriate environment with men and women exercising separately, with separate changing areas and they would ‘understand our ways’. That said, attending fixed time sessions was deemed difficult as previously described there are many competing demands on their time often with higher priority.

2.2 Food and eating practices

Accounts of food and eating practices were at least partly informed by concepts and experiences common to this respondent group. Family expectations impacted on dietary choices, food preparation and consumption. In relation to food practices the importance attached to group norms and social values was a theme common across studies. These norms often acted as barriers to encouraging lifestyle change as lack of knowledge was not the main barrier but a complex value hierarchy.

A ‘traditional’ South Asian diet presented particular problems for their health; amount of oil used in cooking, fried foods and the high sugar content and popularity of Asian

sweets. South Asian foods were viewed as 'risky' by many and this caused difficulties when adapting their diet. Grace et al., (2008) found this belief influenced by health professionals and South Asian patients misinterpret or misunderstood health professional's advice regarding 'diet' and 'dieting'. Few mentioned cutting out these foodstuffs instead accounts of 'restraint' of 'risky' Asian foodstuffs was common and contrasted with White Europeans who were more likely to remove 'risky' items completely from their diet (Lawton, Ahmad, Hanna, Douglas, & Hallowell, 2008). Health was a consideration with food practices but was interwoven with other issues and concerns. Insight came from those participants with diabetes or CHD who felt changes to their traditional recipes could not be made without having to choose 'less appealing' Western food. Concern with difficulty obtaining suitable food that was palatable and acceptable with Western food being described as bland and unpalatable. Some of the authors felt that positive aspects of traditional food practices should be reinforced, including cooking from scratch using a variety of fresh and healthy ingredients, offering fresh fruit and nuts rather than sweets with the idea that traditional Asian foods can be made non 'risky' without compromising taste.

Food and health practices in particular were seen to be influenced by peers or elders due to the social and cultural norms that they recognised (Ludwig et al. 2011, Greenhalgh et al., 1998). The influence the social environment and, in particular, the views of peers and 'significant others' a theme as engagement in behaviour which is practiced by, and valued by their peers. Consumption of foodstuffs plays an important role in social networks with the of offering and receipt of food, the creation of social networks by 'gift-giving' in the form of luxurious or traditional food and the social significance of cooking for guests and of celebratory meals. This strong hospitality culture was pivotal and the role of consuming South Asian food viewed obligatory otherwise risk offence or alienation from the community (Lawton et al., 2008). Social expectations were evidently highly valued and therefore certain standards and food preparation were expected to please guests. Visiting relatives was problematic as healthy choices were not available (Stone et al., 2005). What is accepted to be healthy (small portion size, limited rich and fatty food) was seen as less important than the social norms of hospitality (Grace et al., 2008). Lawton et al., (2008) found most participants continued to consume South Asian foods despite

concerns that they may be detrimental to their glycaemic control. Restraint was the central method used to allow a balance between the risks associated with eating traditional food against alienating themselves from their culture, families and communities. For those diagnosed with diabetes few suggested ways that they had changed or adapted their diet since being diagnosed other than when cooking use of Ghee for special occasions only (Stone et al., 2005).

Males, reportedly, had little or no input into food preparation so were reliant on female household members to cook food appropriate for them. Grace et al., (2008) found some felt 'control' of their diet should be imposed and policed by family members so through external influences.

Responsibility to maintain traditional practices was felt by most women and younger women described receiving advice (whether it was asked for or not) from their elders to achieve the correct practice. Women also expressed a moral conflict between individualist goals and collectivist goals (for example, the individual goal of healthy eating compared with the shame to the family of not providing guests with generous 'special menu' food). Both first and second generation women struggled with these conflicts. However, Grace et al. (2008) found that although older women felt strong pressure to conform to traditional norms and expectations; younger and second generation women felt able to resist pressure to conform.

2.3 A 'healthy' weight

Many experienced considerable difficulties in trying to lose weight and this may be related to the individual nature of weight loss. As noted with both physical activity and dietary modification doing things for oneself is not highly regarded in this group. The idea of work as a unit makes weight loss difficult, as changes cannot be made without inclusion of all household members and having the families support. Some with diabetes described having to have meals separate from their family who continued with their usual diet status (Greenhalgh et al., 1998).

Body image was recognised by many authors as a potential barrier to healthy lifestyle behaviours. Positive personal appearance being related to a larger size is a cultural barrier that outweighed personal motivation for weight loss, (Farooqi et al.,

2000) and for older people weight loss was seen as potentially weakening. This may in part be due to the culturally acceptable nature of being of a larger size, weight is not always perceived as unhealthy and may be viewed as indicating good health, weight or status (Greenhalgh et al., 1998). The extent to which importance was attached to an ideal body size differed by gender, age and it was not always women that were keen on managing weight (Darr et al., 2008). For women, dieting was not common, only if the issue was raised by a health professional had they considered dieting for weight loss (Ludwig et al., 2011). This study also found perception of own weight was often not correct with most perceiving themselves not overweight when body mass index calculations showed they were. Weight perception may also be affected by modesty traditions as some pointed out that a woman dressed in traditional clothing was not always aware of her shape (Ludwig et al., 2011). Women viewed weight gain as an inevitable path in a woman's life post-children and due to age (Lawton et al., 2008) linked with underlying beliefs of fate and destiny which impacted motivation to make changes. Although, where there had been positive experiences of weight loss seen in a peer or elder this acted as motivation to diet (Sriskantharajah et al., 2006).

Discussion

These ten studies provide insight into possible reasons why South Asian perceptions may be at odds with individualistic motivations in commercialised healthy living (e.g. gym membership) and with current models of behaviour change. Concepts such as self-efficacy or empowerment where emphasis is placed on individuals and their self-efficacy (e.g. Health Belief model) may not be readily applicable to South Asians along with the current focus on self-management of disease. This requires considerable motivation and prioritisation of health by the individual but when the benefits of engaging in health-related behaviours are not readily identified and long-term health not a prioritised goal.

High importance is attached to group norms and social values, so supporting initiatives, which receive community endorsement, may help to alleviate people's anxieties taking time out from their obligations to perform exercise. Delivering education, advice and support to the whole family given the broader role that the

shared consumption of South Asian food plays in community life is important and may help reduce concerns about not participating in cultural acts. There is also need to consider the nature of social support networks, essential for promoting health behaviour change, i.e. extended families living within households as social support from family members will encourage healthy diet and physical activity adherence.

Lifestyle advice given by health professionals needed to be culturally appropriate to enable individuals to put the information into practice. Health professionals need to be aware their advice can lack acceptability and therefore unlikely to be followed. Within a health professionals role it appears sensitivity to patient motivations and cultural commonality would be important areas to be aware. More specifically a need for strategies focusing on healthy cooking practices through the promotion of lower fat authentic versions of traditional recipes and understanding different ideas on body image in relation to health risks will likely assist behaviour change.

Consideration of the term physical activity and activities associated, the amount of exercise, physical limits were often unknown and questioned. Physical activity was not identified as a main factor in the aetiology of obesity and poor physical health; this lack of association should cause concern for health providers. Lack of knowledge and perceived lack of control over health, means behaviour modification is likely to be harder among this group. Walking stood as women's most popular activity for keeping active as this was easily controlled and incorporated into daily routines, accompanied by the benefits of meeting other people. Identifying preferences and activities that are culturally acceptable appear very important within this group.

Proactive targeting of information is needed, combined with specific guidance and reassurance. This should be sensitive to South Asian concerns and motivations, such as those identified here and use of community peer education may be an effective way to assist levels of self-efficacy. For now health promoters may need to consider working with, rather than against, cultural norms, values and individual perceptions. For instance, rather than appealing to the promotion of individual health and personal gain, they might consider emphasising the benefits of physical activity and dietary change in terms of helping people to maintain their roles within their families and to fulfil their obligations to others. Strong family networks and frequent

history of diabetes appears to create strong emotional support among South Asians seeking advice from each other and therefore also means that they are unlikely to seek additional support. Emphasis on support from family to make changes and high regard from informal sources of information (peers, elders etc.) reinforces that family-based educational interventions are useful in these communities to build on beliefs, attitudes and behaviours already existing. It may be prudent to invest energy and resources in raising general awareness through group and community-based initiatives spread in particular through word of mouth as a useful approach for promotion.

Contemporary health promotion is built on assumptions of individualism and self-investment and may need to be rethought for South Asian groups. Typical health promotion is based on education and awareness therefore unlikely that large-scale campaigns are reaching South Asian groups who look to their peers as role models and advisors. Clearly, a number of factors give South Asians their unique sense of identity and belonging and cultural preferences influence engagement with different recreational activities and food choices. In common with other areas of interest relating to people of South Asian origin, it is important to bear in mind the heterogeneity of this broad ethnic group and to be aware that the attitudes and health beliefs of specific subgroups may not be common to all migrant South Asians converting awareness into action. However, considering their health risks, understanding disease risks and importance of engaging in preventive behaviours are imperative for this group. Interventions have previously been based on Western behaviour models & no information regarding the cultural-appropriateness of these exists. The term 'culturally sensitive' has been widely employed to describe initiatives, which have been tailored to increase their appropriateness for minority ethnic communities. However, understanding of the factors to be considered in developing adapted interventions is still developing, within a wider context of competing theory-based strategies. These studies help us to understand the cultural factors responsible for poor adherence to lifestyle advice but more studies are needed on the cultural acceptability of different types of exercise and dietary regimens in South Asians. The development of a framework to better understand the factors underlying South Asian health behaviours and how this relates to the initiation and maintenance of a healthier lifestyle would be of use to health

professionals and service providers in addressing health inequalities among this group. Qualitative research is helping to reveal how social and cultural forces shape health behaviours and can work to explain why information and programmes alone are often not enough to change it.

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Appendix Research



RESEARCH PARTICIPANTS NEEDED

Research exploring, ‘What living a healthy lifestyle for a healthy family means to you.’

- . Are you the parent of children aged 5-12 years of age?*
- . Are you of South Asian background?*
- . Would you be willing to talk about your experiences?*

My name is Anna Lucas and I am a Trainee Health Psychologist completing the Professional Doctorate in Health Psychology at London Metropolitan University. I am conducting research looking at ‘What living a healthy lifestyle for a healthy family means to South Asian families in the UK.’ I am looking to recruit parents to take part in this study.

This project aims to gain an understanding of perspectives on living a healthy lifestyle and related beliefs and behaviours. It is hoped that the results for the study will help those developing healthy lifestyle programmes to support South Asian families better.

If you are interested in taking part confidentially in this study or would like further information about this research, please speak to reception. Thank you.

Appendix B



School of Psychology
Faculty of Life Sciences and Computing
London Metropolitan University
166-220 Holloway Road
London
N7 8DB

Information sheet

Before you decide to take part in this interview, it is helpful for you to understand the purpose of it and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Thank you for reading this.

Why are we running these interviews?

People from South Asian communities in the UK can be up to six times more likely to have diabetes than the general population. The aim of the interviews will be to learn more about what living a healthy lifestyle means to you and also your understanding of diabetes so that ways to prevent this disease can be developed specifically for South Asian populations.

Who will take part?

Parents who are of South Asian ethnicity with children aged 5-12yrs will be invited to take part in the interviews.

What will it involve?

It will last approximately 60 minutes and you will be given the opportunity to discuss your experiences and views on what 'Living a healthy lifestyle for you and your family means to you'. The interview will be run and recorded by Anna Lucas a researcher from London Metropolitan University who is completing research as part of a DPpsych Health Psychology. You will be asked questions by the researcher and the interview will be recorded so that we have a record of what was said.

What will happen to the information that I give?

The recordings will be transcribed, removing any identifying information such as individual or institutional names. The text from the interview will only be accessible to members of the research team. An analysis of the interview will form the thesis for a DPpsych in Health psychology.

Will my taking part be confidential?

All information obtained in this study will be kept strictly confidential. All participants will be asked not to disclose anything said within the context of the discussion. Every

attempt will be made to ensure confidentiality and no-one will be named or identifiable in any way in the reports from the interview

What if I wish to withdraw?

Your participation is entirely voluntary and you may decline to answer any or all questions, and you are free to withdraw at any time. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form.

If you are interested in taking part in the interview please complete the consent form and return to the researcher Anna Lucas.

Thank you for taking the time to read this information sheet which is yours to keep.

Appendix C



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Interview consent form

Participant ID

Date.....

Thank you for your interest in taking part in today's interview conducted by Anna Lucas a DPpsych Health psychology student at London Metropolitan University. Please tick the following boxes if you are in agreement with the statements beside them:

I have read the information sheet regarding the study and have had the opportunity to ask questions.

I understand that my identity will remain confidential. My data will also be kept confidential.

I understand that I can withdraw my data from the study if I provide the researcher with my unique ID code

I understand that my voice will be recorded during the interview on a digital-recorder, and will be transcribed (typed out). My name will be changed in the write up of the interview to protect my confidentiality.

By signing this consent form, you are indicating that you fully understand the information given to you in the information sheet and agree to participate in this interview.

If you have any questions, please contact the project supervisor Dr. Esther Murray: 0207 320 2397 or e.murray@londonmet.ac.uk

Many thanks for your help and your participation is greatly appreciated.

Participant's signature _____

Date: _____

Researcher's signature: _____

Date: _____

Appendix D

Interview topic guide

I am a researcher from LMU and we are aware that South Asians in the UK are up to six times more likely to get diabetes and rates of heart disease are also higher. I would like to understand what 'Living a healthy lifestyle for a healthy body means to you and your family?'

Background:

- 1. Could you tell me a bit about your family**
 - a. who lives at home
 - b. ages of children
 - c. when your family first moved to the UK

Understanding:

- 1. What is your idea of a healthy lifestyle for your family?**
- 2. How much control do you feel you have over yours and your families health?**
 - a. Ability to provide healthy lifestyle?
 - b. Ability to have an impact on your health?
- 3. What role do you feel a parent has in making sure their child has a healthy lifestyle?**
 - a. Keeping them physically active
 - b. Making sure they eat healthily
- 4. What activities would you consider as good exercise or requiring you to be physically active?**
- 5. What areas of yours and your families diet do you regards as healthy?**
- 6. What areas of your diet do you feel as less healthy?**

Motivations:

- 1. To lead a healthy lifestyle**
 - a. For a healthy body
 - b. Healthy mind
 - c. Healthy family
- 175.

Barriers to a healthy lifestyle:

- 1. What things get in the way of you living a healthy lifestyle?**
 - a. Family
 - b. Friends
 - c. Environment – lack of facilities or fresh f & v available
 - d. Cost

Information:

- 1. Where do you get information/advice about leading a healthy lifestyle?**
- 2. Do you look for advice and where?**
 - a. Family
 - b. Friends
 - c. TV
 - d. Mosque
 - e. Magazines
 - f. Internet
 - g. Religious beliefs

Risk perception

- 1. How do you think carrying extra weight might affect you now/in future?**
 - i. *Prompts:* health, physically, emotionally
- 2. Are any of these concerns you have for your child?**

Prompts: now/in the future

 - i. If yes why?
 - ii. If not why not?
- 3. Incidence of type II diabetes within family? Understanding of diabetes risks, prevention & cause.**
- 4. Knowledge & awareness of the higher incidences of obesity-related disease within SA populations?**

Appendix E

Interview questions that developed following progression of interviews.

Topic guide
Beliefs & motivations about leading a healthy lifestyle.
View of their child's engagement in healthy behaviours & their role in influencing this.
Parental & grand-parental control over food/meals/activity (hierarchy), links to affection, the idea of food as reward.
Perceptions of dietary consumption & weight in relation to health, 'dieting'.
Current dietary advice & adherence to this, how relevant/valuable advice is, how accessible health information is, do they seek knowledge or just receive it?
Perceptions & preferences on being physically active, reasons for less aggressive/exercise culture. Use of local leisure opportunities, awareness of facilities & appropriateness of facilities.
Limitations to engaging in healthy behaviours/lifestyle?
Addressing these barriers how?
Where advice & knowledge is obtained from, for example from family, health professionals, the media, religious beliefs etc.
Knowledge & awareness of the higher incidences of obesity-related disease within SA populations?
Incidence of type II diabetes within family? Understanding of diabetes risks, prevention & cause.
What type of information/advice/activities would be appropriate and appealing? Views on location and delivery of an intervention?

Appendix F



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Debrief Sheet

Thank you for participating in this interview.

The aim of the interview was to improve knowledge and understanding on factors which will affect lifestyle change among South Asian families. Also, to explore factors that may affect diabetes risk identifying the particular needs of South Asian groups and use this information to improve health advice and interventions.

Your contribution to this study is therefore very valuable and appreciated. Your responses will be used to improve the prevention of diabetes. The researches focus is on how lifestyle changes can be made among South Asian families to try to prevent diabetes and other lifestyle related diseases using gradual, healthy, and reasonable changes in eating and activity. Changing behaviour takes work so we want to find the best ways of delivering help and support so useful changes can be made.

If, for whatever reason, you later decide that you no longer want your responses to be part of this study, then please contact Anna Lucas (see details below) to have your data removed from the study and destroyed. As a final point, all data recorded during the interview will be written up, removing any identifying information such as individual or family names and locations. Therefore you will remain anonymous.

If you would like more information, or have any further questions about any aspect of your participation in the interview, then please feel free to contact the project supervisor Dr. Esther Murray: 0207 320 2397 or e.murray@londonmet.ac.uk

If by discussing issues around your health and lifestyle, this has caused any unforeseen anxiety or worry, we suggest you contact your GP for advice.

Thank you again for participating and helping with this study.

Yours sincerely,

Anna Lucas

██████████

████████████████████

Appendix G

Memo writing examples

MEMO

Mothers not exercising – lack of time or lack of control over how time spent? Collectivistic culture? ‘I don’t have time’ or should that be ‘I don’t have motivation’?

Time was prioritised around the family and this normally dictated how time was spent i.e. they needed to take their children to school, go to work (four mothers worked part-time), pick them up take them home for a snack before taking them to the mosque, returning home preparing dinner, picking up the children, having dinner and putting children to bed. This routine varied among the mothers however those who did not take their children to the mosque still wanted to be around to support their children to do their homework. Fathers were not implicated in this role and described as having the time to go to the gym or walk to places. Family time was important and mothers felt it unfair to leave children alone at home and were pleased that they could say they never left their children with anybody else.

MEMO

Taking control of health by moving away from traditions? Or moving towards western traditions for health?

Is moving away from traditional South Asian foods in everyday cooking a way for mother’s to take control of their family’s health/ a way of balancing out unhealthy behaviours or acculturation? It is well documented cultural groups change and adapt over time, many minority cultures assimilate to some extent into the majority cultural lifestyles through the process of acculturation, Phoenix and Husain (2007). Mothers were very vocal about needing to be careful about risky (unhealthy) South Asian food, the need to buy low-fat foods and baking and grilling food instead of frying. However, they did not show the same level of concern for engagement with unhealthy aspects of British food culture such as snacking on high calorie snacks (crisps and cake bars) enjoyment of fast food and breakfast cereals.

MEMO

Understanding the relationship between lifestyle and disease – misperceived risk

‘Should I be worried?’

Mothers are influenced by their personal experiences of the risk and they are influenced by how the risk is framed. One mother recently diagnosed with diabetes explained that although her mother and aunts all had diabetes she had previously known very little about the disease and was shocked when she herself was diagnosed. Family members were described as not very open or forthcoming about their conditions and elders were viewed as ignoring and not talking about their health conditions. This appeared to have the effect on mothers that they felt confusion over the actual cause and were not sure what was myth or truth. Stone et al., (2005) found reference to family networks and history of diabetes among family or friends created the main informational sources, which appeared to reduce the need to seek additional support. As the interviews neared the end mothers became very inquisitive about diabetes in particular asking all sorts of questions relating to understanding diabetes, their risk, how it is passed on, what they can do to reduce their risk. However, this was peppered with mentions of 'well it runs in the family' so there is not much they can do or that they have family members who eat very healthily and active now have diabetes or have had heart attacks so this left confusing messages for mothers. South Asians are a 'high risk' group for certain lifestyle-related diseases (heart disease and diabetes) however risk was not related to ethnicity but family genes and lifestyle. Although lifestyle was correctly identified, the particular aspects of lifestyle that increase risk of lifestyle-related disease was much less clear and this is supported by research completed by Darr, Astin and Atkin, (2008) and Farooqi, Nagra, Edgar and Khunti, (2000) on the UK south asian population.

Appendix H

Initial Grounded Theory Codes

1. High use of salt, oil and sugar
2. Cater to guests (traditional, non-traditional)
3. Key components to social gatherings – seated, big portions, buffet, food central
4. Entertaining is whole culture
5. Showing love/kindness/respect with presentation of food
6. Focus on food for health
7. Enjoy seasonal fruit – mangoes
8. Food reputation – bad: mangoes, oil, salt (sugar less so) good: yoghurt and fruit
9. Difficult to make this food healthier but still taste good without a lot of effort
10. Elders don't change
11. Fry ups, special weekend breakfasts
12. Use of shisha
13. Wrong attitude to health
14. Changing cooking practices – baking and grilling
15. Focus on food as main component of health
16. Health vs. weight
17. Corrected by health professionals
18. Conflicting advice – school providing bowl of brown sugar at breakfast club
19. Thin means well-maintained
20. Chubby but not overweight
21. Home cooked food
22. Baking own cakes
23. Expectation we should know what is healthy
24. Healthy but have ill health
25. If unwell would leave it to doctor, wouldn't do any research
26. Leaflets only read headlines
27. Being careful, low-fat foods
28. Sensitive to salt being unhealthy
29. Extra weight associated with increase in health issues
30. Need time to consider self
31. Moving away from traditional foods or healthier lifestyle
32. Enjoyment/accessibility of other foods: fast food, British food
33. Need reminding, support
34. Lighter food as snacking now part of everyday life
35. Removing temptation
36. Poorly managed diabetes
37. High incidence of diabetes
38. Young advising old
39. Adult risk only
40. Ethnicity not an increased risk
41. High sugar in blood, low sugar, sugar-related
42. Same as rest of population
43. Diabetes not explained, no talked about
44. Hard to make changes to food but taste good

45. Sweet tooth
46. Ramadan encourages sugar
47. Dental health and use of sugar
48. Cravings
49. Child's understanding of health
50. Hard to deprive children
51. Influence of British culture, bakery, cakes with cream
52. Whole family has sweet tooth
53. Child's weight understanding the reasons - Puberty will help
54. Normal weight compared with cousins, who child takes after
55. Remarks from family about children's weight
56. 'Their thin, their thin'
57. Born big so expected to continue being big
58. Large = physically stronger
59. Weight an emotional topic – children sensitive
60. Separate food for each children's tastes
61. Crisps and chocolate are favourites
62. Fussiness
63. Enforcing restraint
64. Effort in promoting healthy eating
65. Compromise/negotiation
66. Opposing instruction from family
67. Information vs. confusion (croissants, butter sandwiches healthy, organic healthy)
68. Weekend letting go but difficult to deal with, restriction vs. letting go
69. Child's knowledge and understanding helps – able to check themselves, don't have to nag
70. Hard to deprive – child does not understand
71. Feared having chubby children
72. Meat essential
73. Olive oil better but amount important
74. Availability of junk food, enjoyment
75. Ease and low cost of takeaway food
76. Removing temptation
77. Social nature of food
78. Weekend indulgent – no one restricts
79. Need to control child's intake
80. School supports control
81. Adult enjoyment of food, difficult to set example
82. Lose track of what child has eaten
83. Parents educating children through fun activities (change4life)
84. Knowledge – most things unhealthy (cereals normal but unhealthy)
85. Exercising restriction
86. Confused over advice
87. Checking labels
88. Want guidance
89. Offending elders, grandparents spoiling
90. Fast food cheap enough for children to buy
91. Professional advice increased knowledge – from school about packed lunches

92. More health conscious
93. Increased need to be active
94. Reminder of link between lifestyle and health
95. Incidence of disease
96. Talking about healthy lifestyle more
97. Concern over diabetes being hereditary
98. Culturally specific advice
99. Professional advice – more local, hospital appointments limited (dietitian)
100. Others looking healthy and attractive at older age – reminder you can too
(who are the parent's role models?)
101. Need to be more in control
102. Parent's role to find motivation and advice, not government
103. Worry, concern for husband's health
104. Health impacts of not exercising
105. Link between health and beauty
106. Being at home for children
107. Large family/extended family at home or nearby
108. Providing healthy diet – fruit
109. Pressure and guilt, failure
110. Finding a balance between healthy and being relaxed, compromise
111. Providing generous meal for guests
112. Seeking advice when necessary and being motivated to use it
113. Religious requirements – mosque, family
114. Adult women: swimming, gym, walking, cycling
115. Men: gym, cricket
116. Children: martial arts, taekwondo, swimming, cycling
117. Individual sports more common
118. Indoor exercise equipment – make exercise easier?
119. Fresh air, entertain children
120. Women's clothing
121. Cost of gym and formal exercise in general
122. Men and women separate
123. Use of transport
124. Need somewhere to go
125. Illness: asthma, thyroid
126. Exercise – need someone to go with
127. Weather restrictions on physical activity
128. Outdoor safety an issue
129. Child active as always moving
130. Time – routine
131. Children not wanting to walk
132. Outdoor space restricted activities (no balls)
133. Motivation to go to park

Appendix I

Examples of initial clustering of codes

Code: FOOD AND SOCIALISING

Brief definition: A key element of hospitality was the social nature of food and its role as the main entertainment.

Full definition: Food played a key role in entertaining and was central to weekend socialising and importantly socialising together as a family with food.

When to use: Apply this code to all references to acknowledge role of the social nature of food.

When not to use: Do not apply this code when referring to being treated as a guest or letting go at weekends

Example:

P7: we go to my mother-in-laws one day and one day my mums house and that's when we probably have our fall-out Indian meal or then its leg a leg roast or chicken roast or and that's with all the fatness that's involved

P3: I think that there is lots of lovely food around you and that is a main part of the culture and honestly they are delicious I can't blame my children because even I as an adult feel like (laughter) yeah it's difficult for me to control it when the table is full of all the sweet things and after food you are just and enjoying these foods and it is difficult to stop yourself

Code: SWEET TOOTH

Brief definition: Mothers described their family as having a sweet tooth

Full definition: Mothers describe finding it hard to refrain from sweet foods as they, their family or their culture in general has a sweet tooth

When to use: Apply this code to all references when mothers make about liking sweet food.

When not to use: Do not apply this code when parents are referencing culturally significant food

Example:

P6: we are generally very sweet toothed people in the house we love our cheesecake we love our dessert and I tried to minimise it and one-off is ok once a week you know

P1: It's the culture like we are having Indian sweets. Indian sweets is a delicious dish...I used to have it every Ramadan we used to have everyday with sweet like you have dessert we have sweet after its only that Ramadan that puts you onto sugary stuff.....when I am fasting I really need all that to get my energy and I am not eating all day so I need something sweet.

P2: I have a really sweet tooth... Western sweet things like penny sweets that type of stuff and show laces and cola bottles and those types of things they are my weakness.... my son is exactly the same he will gorge on anything sweet

Code: TRADITIONAL VERSUS WESTERN

Brief definition: For all family's there was a combination of traditional and western meals served in their household, However, traditional meals were more likely to be consumed only at weekends.

Full definition:

Where mothers describe the positives and negatives of cooking or eating traditional or western food. The preferences of family members and when and which meals they eat traditional or western food and with who and what this depends on.

Example:

P7: to be honest even when I do make curries I love curries and chapattis I do love it but I can't be bothered making it and the chapattis process of making it.

P2: we would have more of an englishy breakfastthey will have a bowl of cereal toast with eggs or butter and jam and things like that Philadelphia cheeses.

P4: we have dinner.... either pasta or something Asian like a curry and rice or curry and chappattis

P1: they say, 'no mum brown bread and egg or sardines' or they will go for tuna that's all but I think they should have curry meat and everything together as well that's got more spice in it.

P:7 I try to do it once a week (traditional meal), maybe once every two weeks because we have it at my in-laws at the end of the day so what it is my husband is not too fussy thank goodness he is not a curry lover so it is ok it works out fine.

Code: CULTURALLY SIGNIFICANT FOOD

Brief definition: Foods parents describe as important in their culture

Full definition: A number of foods were described as having particular cultural relevance which mother's either identified as influencing health in a positive, negative or sometimes positive and negative manner.

When to use: Apply this code to all references to acknowledge the foods/ingredients linked with their culture.

When not to use: When referring to having a sweet tooth.

Example:

P7: Our Indian diet is lots of oil and purified ghee which is purified butter and cream and things like that

P5: I mean as Asians we tend to use quite a lot of oil in everything that we cook

P1: If you don't have spice you get tummy ache and all that and if you are stronger you can actually take these spices and its good for you like ginger, garlic they are the best for you so if you want to get ginger in your body then try it with a curry

P4: I think my sleep my diet everything I wasn't drinking any yoghurt drinks or yoghurt so I think these things especially affected my lethargicness and all that

Appendix J

Conceptual coding

Conceptual category	Selective category	Codes	Example of Open codes
Cultural identity	Food traditions	Acculturation	<i>Traditional food more preparation</i>
			<i>Prefer western main meals</i>
			<i>Traditional meals for hospitality</i>
			<i>New traditions</i>
		Culturally significant food	<i>Salt, oil and sugar</i>
			<i>Fruit selection</i>
			<i>Role of spices</i>
			<i>Daily dairy intake</i>
		Having a sweet tooth	<i>Crave sugary, sweet food</i>
			<i>Sweet tooth is cultural norm</i>
<i>Family has a sweet tooth</i>			

Conceptual category	Selective category	Codes	Example of Open codes
Cultural identity	Value of hospitality	Frequency of hospitality	<i>Food as main entertainment</i>
			<i>Social nature of food</i>
			<i>Social norms</i>
			<i>Treating guests</i>
		The nature of hospitality	<i>Children not restricted</i>
			<i>Difficult controlling intake when a guest</i>
			<i>Frequent nature of being a guest</i>
			<i>Grandparents treat foods</i>

Conceptual category	Selective category	Codes	Example of Open codes
Cultural identity	Leisure time	Being active	<i>Children active at school</i>
			<i>Parent motivation</i>
			<i>Adult health benefits</i>
			<i>Places to walk safely</i>
			<i>Popular physical activity types</i>
		Religious duties	<i>Mosque is after school activity</i>
			<i>Car needed for busy routine</i>
			<i>Religious dress</i>
			<i>Single sex activities</i>
		Letting go	<i>Time to relax</i>
			<i>Be indulgent</i>
			<i>Out of control</i>
			<i>Can't be too strict about food</i>

Conceptual category	Selective category	Codes	Example of Open codes
Health beliefs	Establishing a healthy lifestyle	Dealing with fussy eating	<i>Failure to reduce fussiness in child</i>
			<i>Child will grow out of fussy eating</i>
			<i>Strategies to deal with their fussy eating</i>
		Cooking with fresh ingredients	<i>Home cooked is healthy</i>
			<i>Proud to provide home cooked food everyday</i>
			<i>Home cooked meals regularly</i>
			<i>Home cooked meals tradition</i>
		Having breakfast	<i>Having breakfast daily</i>
			<i>A filling breakfast more important than the nutrition</i>
			<i>Western style breakfast</i>
			<i>Restricting sugar</i>
		Limiting takeaway/fast food	<i>Fast food is easily available</i>
			<i>Fats food is cheap</i>
<i>Easier not having to cook</i>			
<i>Children enjoy it and pester for it</i>			

Conceptual category	Selective category	Codes	Example of Open codes
Health beliefs	Seeking or receiving advice	Following health messages	<i>Lower fat foods</i>
			<i>Adult focused dietary knowledge</i>
			<i>Changing cooking techniques</i>
			<i>Strategies to restrict children's intake</i>
		School's support	<i>Packed lunch rules</i>
			<i>Provide advice around health eating</i>
			<i>Healthier packed lunches</i>
		Professional advice	<i>Not always easy to access professional dietary advice</i>
			<i>Professional advice trustworthy</i>
			<i>Elders ignore professional advice</i>
		Family advice	<i>Advice on healthy eating from older children</i>
			<i>Advice from family members with health conditions</i>

			<i>Family offer contradictory advice about diet</i>
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Conceptual category	Selective category	Codes	Example of Open codes
Health beliefs	Moving away from tradition	Cooking practices	<i>Use non-traditional cooking techniques for health</i>
			<i>Use less oil, sugar and salt in cooking</i>
			<i>Adapting traditional recipes to be healthier</i>
			<i>Eating less traditional food</i>
		Snacking	<i>Snacking not a customary tradition</i>
			<i>Snacking is a common habit taken on from British culture</i>
			<i>Difficult controlling child intake at school or after school</i>
			<i>Snacking is hard to control</i>

Conceptual category	Selective category	Codes	Example of Open codes
Barriers to being healthy	Misperceptions	A healthy weight	<i>Dietary intake the dominant factor in weight gain</i>
			<i>Family opinion of child weight</i>
			<i>Comparing child weight with siblings/cousins/parent's shape</i>
			<i>Adult weight an issue when uncomfortable</i>
			<i>Puberty will reduce child's chubbiness</i>
			<i>Weight not an issue until they are older</i>
			<i>Children more self-conscious with age and motivated to be healthier</i>
			<i>Growing out of weight</i>
		Health risks	<i>Unsure why family has high rates of lifestyle related disease</i>
			<i>Unsure how lifestyle-related disease develop</i>
			<i>Health risks are hereditary</i>
			<i>Children at low risk until</i>

			<i>adults</i>
			<i>Unsure how to reduce health risks</i>

Conceptual category	Selective category	Codes	Example of Open codes
Barriers to being healthy	Constraints	Lacking time to be active	<i>Familial commitments reduced time for individual exercise</i>
			<i>Use of car essential for busy schedule</i>
			<i>Large family and/or extended family nearby</i>
		Environment	<i>Restricted space</i>
			<i>Lack of safe spaces</i>
			<i>Ease of access to fast food</i>

Appendix Professional Skills competency

Appendix A

CURRICULUM VITAE

NAME: **Anna Lucas**

PROFESSIONAL TITLE **Trainee Health Psychologist**

TRAINING: Common Assessment Framework Train the trainer – Hackney Learning Trust
Solihull Training – First Steps Psychology
Advanced research methods - London Metropolitan University
Shape Up facilitator - Weight Concern, University College London
Social marketing workshop - Change4Life
Smoking cessation advisor Level 3 - Islington PCT
Child obesity intervention training Level 1 - Westminster PCT

AUGUST 2012 - DATE

Homerton University Hospital NHS Foundation Trust

Public Health Coordinator for Children's Centres

- Enhancing existing services for families and children living in the local area, and developing and delivering new ones that are sensitive to the cultural mix of the area based on identified needs.
- Developing close links with health professionals, Local authority, GPs, pharmacies, charities and education to ensure integrated holistic care programmes are developed that meets the need of local population & avoid duplication of services.
- Advising on use of appropriate evaluation techniques.
- Lead on the monitoring and reporting of the monthly health activity data which contributes to the Children Centre key performance indicators and targets and produce a quarterly report on progress against work plan. Management of data officer who works on the report.
- Sit on a number of steering groups relating to the Healthy Child programme
- Developing networks with other organisations and community groups
- Supporting the development and launch of health promotion initiatives such as the Breastfeeding Welcome scheme and Healthy start vitamins.
- Childhood obesity prevention work - supporting the roll out of the HENRY programme, dissemination of NCMP data to staff & development of a healthy lifestyle intervention for obese pregnant women.
- Identifying training needs for staff in relation to the healthy child programme and some delivery of training such as smoking cessation, raising the issue of child obesity and motivational interviewing etc.

MARCH 2012 to AUGUST 2012

Bromley Healthcare

Health Development Advisor (maternity cover)

- Co-ordinate evidence based approaches to promoting a healthy lifestyle among adults in Bromley. This involves implementing projects in various lifestyle areas such as CHD prevention, promoting healthy eating, encouraging increased rates of physical activity and promoting safe use of alcohol.
- Manage and support the 'Walking for health' programme across the borough, managing volunteers, set up and promotion of walks.

- Lead on the implementation of the Community Lifestyles Advisor training, the aim of which is to build local community capacity to support and empower local people to adopt healthier lifestyles.

FEBRUARY 2011 to date

Professional doctorate in Health Psychology, London Metropolitan University

Teaching

- London Metropolitan University - MSc Health psychology
- Kingston University - BSc Psychology
- Middlesex University – MSc Health Psychology

Consultancy

- London School of Hygiene & Tropical medicine - Obesity related projects
 - As part of the qualitative evaluation of National Child Measurement Programme I delivered interviews with parents whose children received advice on their child's BMI status in the overweight & obese categories. Delivered analysis of data for DoH report.
 - Completion of grant proposals, systematic reviews & giving a psychological perspective on obesity interventions & implementing behaviour change theory.

JULY 2010 to JULY 2011

London Metropolitan University

Research Assistant

- Delivery of, 'Tackling Health Promotion in Practice' training to frontline health professionals aimed at giving them the skills to raise issues surrounding physical/mental health issues (obesity, smoking etc.).
- Development of materials for health professionals focused on goal setting.
- Evaluation of the training package: running focus groups, telephone interviews, input & analysis of questionnaire data.

DECEMBER 2009 to AUGUST 2012

Guys & St Thomas' NHS foundation trust, Maternal & Fetal research unit

Health Trainer for UK Pregnancies: Better Eating & Activity Trial (NIHR funded study)

- Supporting the development of an individually tailored 'life style' package for obese pregnant women
- Research duties include the delivery of the intervention within group sessions giving tailored advice on physical activity and diet with a strong focus on goal setting.
- Working alongside a multidisciplinary research team midwives, dieticians, physical activity specialists, social scientists, and psychologists.
- Obtaining outcome pregnancy data & use of study specific data management system.

DECEMBER 2008 to NOVEMBER 2009


Islington PCT, Stop smoking service

Level 3 Smoking cessation advisor

- Providing one-to-one evidence-based smoking cessation treatment & behavioural support at housing estates, university, college & postal depot.
- Clients mainly fell into 'hard to reach groups' such as long-term unemployment, mental health problems, learning disabilities & substance abuse.
- Stop smoking promotion campaigns & events at community centres.


Appendix B


First few slides of presentation

Homerton University Hospital 
NHS Foundation Trust

Anna Lucas
Public health Coordinator for Children's Centres


Incorporating hospital and community health services, teaching and research



Homerton University Hospital 
NHS Foundation Trust

My role

- **Ensuring integrated holistic care programmes**
 - Developing close links with all professionals
 - Meeting needs of local population
 - Avoid duplication of services
- **Develop & deliver programmes**
 - Identifying need
 - Cultural mix of the area
- **Supporting CCs to meet their targets**



- One in four residents aged under 20
- 21,000 under 5s currently living in the borough

Primary Prevention

- Prevent disease
- Promote health behaviours

- Pre-school age is a critical period for targeting interventions
- Opportunity to target parents' attitudes, beliefs, knowledge & behaviours
- Learning healthy habits early in life helps to ensure a long life of health & enjoyment

Babies 0-18 Months

Free activities and support for Hackney families with a child aged 0-18 months



- Relax and enhance the crucial bond with your baby at a **baby massage** session
- Find out about giving your baby their **first foods**
- Receive **information** to keep your baby healthy
- Check that your baby has had all the **immunisations** they need
- Get support with **breastfeeding**
- Get support with **sleep routines**
- Make **new friends** for you and your baby

Appendix C

Looking at the **pro's** (reasons for) and the **con's** (reasons against) changing your behaviour can help to increase your motivation as you may come to understand what is standing in the way of your behaviour change.

1.....

2.....

3.....

4.....

5.....

Reasons to change



Change Behaviour



Reasons not to change

1.....

2.....

3.....

4.....

5.....



A Healthy Start for All

Information session

This session will support you to champion the Healthy Start scheme to families.

Learn about:

- Why Vitamin D is important
- Who is at increased risk of deficiency
- Information about the scheme and who is eligible
- How the scheme operates
- How to promote the scheme

Date& Time: Tuesday 26th March 2013, 12.30pm -2pm

Venue: [REDACTED]

Lunch will be provided
Promotional materials available

Who should attend: Anyone who works with families with young babies
-Children's Centre staff, play & family support workers, any volunteers, health visitors, midwives, student midwives etc.

Conditions of booking

- The **deadline** for bookings is **Friday 22nd March**. However, places are allocated on a first come, first served basis.

To **BOOK** complete & return the slip below by email to Anna.Lucas@Homerton.nhs.uk or post to: [REDACTED], **Public Health Coordinator**, [REDACTED] London, [REDACTED]

BOOKING FORM Please book me on

Healthy start for All information session:

Tuesday 26th March 2013

Your name: Job title:

Name of your Manager: Contact tel:

Dept / Children's Centre (if applicable):

Today's date:

Appendix E

Exploring the impact of the 'Cook and Eat' programme on family eating behaviour

Theme 1 Key knowledge increase	Theme 2 Key behaviour change	Theme 3 Barriers to change	Theme 4 Dealing with fussy eating	Theme 5 Maintaining healthy changes
Importance of eating a variety of foods (eatwell plate)	Swapping to brown rice	The extra time it take to cook healthy recipes	Children more adventurous & open to trying new foods	A course manual with content to refer back to for support
Healthier cooking techniques	Reducing use of oil, salt	Compensating the change in flavour when reducing oil, salt & frying foods	Realising children's tastes change & should regularly try new & disliked foods	A recipe binder to separate breakfast, lunch & dinner recipes & keep recipes safe.
Ideas for cooking healthier recipes	Halving the amount of sugar in recipes	Price of vegetables	Importance of involving children in cooking preparation	Refresher session: on topics, recipes & share experiences after the course
More aware of hidden sugars & fat in foods	Baking and steaming food instead of frying	Failing to recall information learnt on the course	When one child is a fussy eater to still provide other children with varied diet	For parents with school children info on healthy packed lunches
Appropriate portion sizes for children & adults	Swapping high sugar cereals for lower sugar alternatives	Partners complaining about the changes		Provision of physical activity classes for adults
Understanding nutrition labelling	Using nutritional labels for healthier choices			
	Swapping from sugar to fruit on porridge & desserts			
	Cutting out high sugar drinks			

Introduction

The majority of parents at the focus group attended the Cook and Eat course between 2-6 times with three of the seven parents having attended 5 or 6 times. The course was described by all as very enjoyable with no negative features. Key components that made the course so enjoyable included the opportunity for parents to cook with their children without any time pressure or worry over the mess they created so they could relax, cook and

get messy together. The use of cultural recipes and wide variety/type of food used was exciting and parents liked being able to provide input as to what they wanted to cook next. Overall, attending the course increased parent's perceived self-efficacy in providing a healthy diet for their families particularly their ability to stick to healthier and more nutritious foods through the recipes and cooking techniques learnt.

Main themes that arose from the Cook and Eat focus group

Key knowledge increase

In terms of nutrition knowledge and having the confidence to make healthy choices parents described finding it easier to maintain healthier cooking practices and eating habits since attending the course/s. Also, that their ability to stick to healthy and more nutritious foods had increased. Most felt already aware that home cooking and cooking from scratch was important prior to attending the Cook and Eat course however they learnt new ideas so they could have more variety in their diets and recipes to rely on. One parent explained,

'I used to buy the green salad already made and I understand it is so fatty but now I make green salad at home and it's more healthier.'

The course made parents more aware of hidden sugars and fat in foods for example, the amount of sugar in cereals and fruit smoothies and that crisps lacked nutrition.

'I knew there was a lot of sugar in some things but I was surprised at how much.'

Understanding nutrition labelling better helped parents to feel more confident in making healthier choices particularly around cereals, drinks, desserts and snacks. Some regularly used the food labelling card they received from the course to help them assess the nutrition of products in the supermarket.

'They gave a really good card about how much sugar should be in things and I give it to my son at the supermarket and he like to go round and look at the cereal so I get him to go round and take it to the cereals and choose a healthy one.'

Key behaviour change

Each participant described changes they had made to their families diet which they had been able to stick to, these changes were the most common to all: halving the amount of sugar used in recipes, baking and steaming instead of frying, swapping high sugar cereals for lower sugar alternatives, adding fruit rather than sugar to porridge and desserts, cutting out high sugar drinks, reducing salt and oil and swapping to brown rice.

'The sugar as well because when I used to do the porridge I poured the sugar on but now I use banana and dried fruit and sometimes my husband likes it as well as like the idea of some oats.'

'I get the microwave porridge I don't have time to stir but it is nice to make the proper porridge.'

'The oil I have cut back quite drastically because in Indian cooking we can use quite a lot of oil in cooking.'

'I think it has added more time to my shopping because I check things before throwing them in my trolley but it is worth it.'

'Before I used to eat vegetables not much but now I make sure for all of us.'

A couple of parents had taken what they had learnt and shared it with others to encourage them to reduce the amount of sugary drinks their children have and to use the healthy recipes received from the Cook and Eat sessions.

All parents tried new ways of cooking after the course and many had not found this too difficult to implement however several did find they had to practice several times before they had been able to make the food taste pleasant. For example, the amount of oil, salt and frying of foods was reduced they found it difficult to compensate for the change in flavour by doing this.

Barriers to change

Parents mentioned that sometimes they could not provide meals that were as healthy as they would like due to the added time this could often take. For example, one parent would like to make traditional porridge but instead she used ready-made porridge (higher in sugar and more processed) because she felt she did not have the time to stir the porridge.

'I get the microwave porridge, I don't have time to stir but it is nice to make the proper porridge.'

The cost of food in terms of the price of vegetables was mentioned as a barrier to buying vegetables as regularly as they would like. Another barrier was forgetting the information that they had learnt on the course and not being able to remember which options were healthiest and also losing recipes they received from the course.

'Using less salt has been difficult I think that I forgot about it I just want the taste of the food but now I think I am going to use less after today.'

The change in taste was described as a reason for it being difficult to make the changes they wanted to in terms of cutting down on salt, oil and frying.

'I don't think I have made any changes to salt as when you taste it you should have taste, I am not adding sugar but I am adding salt.'

'Where possible I have tried to cut back (on oil) but it is quite difficult where you are frying off the spices to get that flavour back where you have cut out the oil in there and sometimes I fail miserably.'

Some women's spouses initially complained about changes in taste of their food and that they expected a 'decent' meal after a long day at work. However, most spouses were described as coming round to the changes and were motivated by the health benefits such as reduced cholesterol. Others found their spouses objections too difficult to deal with so had to make more compromise than they wanted.

'My other half works all day and wants to come home and have a decent meal and he is tired and he says why does this taste of nothing, they kind of sabotage it for you they say ok I understand but pass me the salt'

'My husband he says I don't like the taste where is the taste if he is waiting for a biryani with less salt he says I don't like it make me something else.'

'He says he needs taste if it doesn't taste nice he won't eat it and he say you eat by yourself it's good for you not for me so I am still struggling.'

Dealing with fussy eating

Attending Cook and Eat sessions was described as important for both parent and child for reducing food fussiness. For children, by being part of a group and involved in the cooking process encouraged them to be more adventurous and try new foods particularly foods they had previously disliked. For parents it helped them realise their children's tastes can change and they were often less of a fussy eater than they had realised. Also, a few parents found that since the training they were more likely to involve their children in cooking preparation and this improved the child's eating behaviour at meal times.

'Yeah my older son is quite fussy so with my daughter I would tend to give her what I used to make for him and coming here I realised no she is not fussy she likes and eats anything.'

'Because the children are cutting it and mixing it and squishing it themselves they enjoy it and are happy to try more in that environment it is easier.'

'Here it was good she could get messy and it was not a struggle.'

'It gives them a better appreciation of food not necessarily where it comes from but she now understands what the food looks like before we chop it up like a cucumber what it looks like whole.'

Maintaining healthy changes

Parents came up with a number of ideas for helping them continue to provide a healthy lifestyle for their families. Firstly, a manual from the Cook and Eat programme containing all the content from the course which they could keep to remind them and for them to refer back to for support. Secondly, a binder to keep all the recipes and separate breakfast, lunch and dinner recipes they received from the course. This would help them to find and refer back to the recipes they learnt and also to share with family and friends more easily. Thirdly, to have a refresher session which would remind them of the topics and recipes they covered and to hear how parent's from the group have got on with cooking healthily at home.

'A refresher would be good if you could come back and go over stuff because sometime life catches up and you just forget.'

One final suggestion was that different levels and types of courses would be useful to provide a next stepping stone with more complicated recipes and ideas.

'Cook and eat sessions for men would be good, one man came he spent most the time in the garden with the kids.'

Also for parents with children of school age to receive information on providing healthy packed lunches. One last suggestion was the provision of more physical activity classes for adults to support a more rounded healthy lifestyle.

Conclusion

Notably the course supported children to try and appreciate tasting new foods and begin to enjoy a wider variety of foods. For parents, it made them recognise they may have to try a food several times or more with their children before they get used to it and to use different techniques to introduce them to new foods or foods they do not like. Research has shown it is important to encourage parents to provide early, positive and repeated experiences with foods such as vegetables to encourage children to like them. Infants develop innate preferences for sweet foods, but these are modifiable through early exposure. This early exposure to a diverse range of tastes depends on parental food choices, since parents are the primary food providers for young children and also important role models. These kinds of strategies can prevent the development of fussy eating behaviours or fear of new foods. The fact parents felt they came away from the course with lots of new cooking ideas, healthy eating expertise and have continued to use some or all of this knowledge at 3, 6 or 12 months on is very positive and indicates the course's longer term impact on family health cooking and eating choices. Linking healthy eating projects with local exercise and physical activity programmes might help maximise the impact on tackling overweight and obesity.

AppendixF

Children's Centre Health Update newsletter for staff



The newsletter features a red header with logos for Hackney, Hackney Learning Trust, Homerton University Hospital, NHS, and NHS Foundation Trust. The date is March 2013, Issue 5. The main title is 'Children's Centre Health Update'. There are three main sections: 'Ways to Well-being' during pregnancy, 'Healthy Start Vitamin uptake', and 'Let's Get Healthy with HENRY'. Each section includes text, images, and contact information.

Hackney **hackney learning trust** **Homerton University Hospital** **NHS**
NHS Foundation Trust

March 2013 Issue 5

Children's Centre Health Update

'Ways to Well-being' during pregnancy

A new service for obese pregnant women, starting soon!

April will see the launch of a pilot initiative designed to reduce serious complications such as gestational diabetes and hypertension in obese pregnant women.



What's it all about?
The 8 weekly group sessions last 1 1/2 hours and are designed to encourage positive dietary and lifestyle behaviour changes that can be sustained. In the long term a group health walk is included and additional pregnancy yoga classes will be available. The course is a rolling programme so women won't have to wait long before they can start, and the pilot will last for a year.

What can you do?
Look out for posters and fliers advertising the service which will soon be in all children's centres, doctor's surgeries, pharmacies and community venues, and signpost any ladies who might benefit from the programme to get in touch to book a place.
For further information contact Lindsey Miller, Children's Dietitian Lindsey.Miller@homerton.nhs.uk or Anna Lucas, Public Health Coordinator for Children's centres anna.lucas@homerton.nhs.uk

Healthy Start Vitamin uptake

Congratulations to everyone promoting and delivering this scheme, 6,000 of each type of vitamin have been distributed since the start, last April.
Numbers of individuals registered on the scheme suggest that people are registering, collecting one lot of tablets/drops and not returning to collect subsequent bottles – **please REMIND parents to collect their repeat prescriptions.**
Our data shows that we need to improve uptake across the board, but particularly in children. For more leaflets, posters, application forms please contact anna.lucas@hackney.gov.uk

Let's Get Healthy with HENRY – New groups starting soon

The 8 week programme is designed to help parents with young children to have a healthy lifestyle & help to prevent & reduce childhood obesity.

- Geinsborough CC – starting 17th April
- Thomas Fairchild CC – starting 22nd April
- Linden CC – starting 28th May

Contact: anna.lucas@hackney.gov.uk



henry
The Healthy Eating and Nutrition Initiative

A Healthy Start for All
FREE vitamins to help you and your child stay healthy.
Visit your community pharmacy or all your GP practices for health advice.

Children's Centre Health Update

July 2013 Issue 8

Smokefree Homes and Cars campaign 2013

The Smokefree Homes and Cars campaign is running throughout June and July 2013 raising awareness of the dangers from smoking in the home and car.

Millions of children in the UK are exposed to second hand smoke that puts them at increased risk of lung disease, meningitis and cot death. Secondhand smoke contains harmful cancer causing toxins and poisons that are unknowingly damaging children across the country every day.

Over 80% of secondhand smoke is invisible and odourless so no matter how careful you are children still breathe in the harmful poisons.

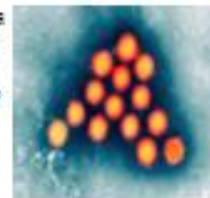


The Smokefree campaign leaflets contain a pledge card for parents to sign to keep their home & car smokefree.

They can then send this freepost to receive a free goodybag to help them keep their pledge.

New vaccine offers babies protection against rotavirus

From today around 675,000 babies a year in England will be offered a new vaccination to protect them against rotavirus. Rotavirus infection is the most common cause of gastroenteritis (vomiting and diarrhoea) in children under 5. **Nearly every child will develop it by 5 years of age.** It is responsible for 130,000 visits to the GP and 13,000 hospitalisations for dehydration every year.



Incorporating hospital and community health services, teaching and research

What to feed & How to Feed

The Children's Centre dietitians are part of the Homerton Hospital Community Dietitians team. We strive, alongside other Children's Centre staff, to help reduce the health and social inequalities that may prevent children across Hackney from achieving their full potential.



Our work contributes to Public Health outcome indicators for breastfeeding rates, excess weight in 4-5 year olds and tooth decay in children aged 5.

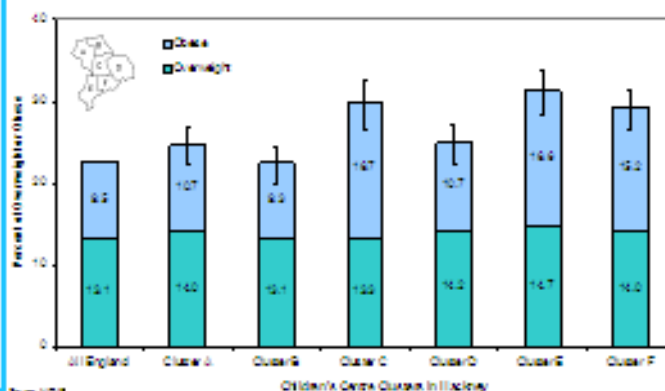
The most common problem we come across in our clinics is poor quality diets. This can result in children having low intakes of nutrients such as iron, which is essential for supporting normal growth, development and learning. Poor growth can also result if the diet is low in energy and/or protein. Poor quality diets are also strongly associated with obesity because many foods of poor nutritional value are calorie-dense eg: biscuits, crisps and soft drinks.

Providing advice on what to feed children is central to what a Dietitian does but we also encourage people to think about how children are fed, and this is the theme for the training we are offering this month at the Homerton Hospital. The 'Responsive Feeding' training will look at how common feeding practices can adversely affect the future eating habits of infants and children. It will be a practical interactive session and is ideal for anybody who works in the Early Years setting. First Steps will also be contributing. Written by Anna Scott, Children's Centre Dietitian.

Hackney rates of Overweight & Obese in reception year

The percentage of Overweight children at reception is very similar in each Hackney cluster to England rates, however the percentage of Obese is much higher in clusters C, E and F.

Weight in Reception in Hackney by Children's Centre Cluster, 2011-12





The Lullaby Trust

The Lullaby trust (previously FSID) provides expert advice on safer sleep for babies and supports bereaved families and raises awareness on sudden infant death. www.Lullabytrust.org.uk



Hackney is ranked 2nd in terms of volume of SIDs in the last 6 years across all 6 London boroughs.

The charity has provided Hackney with free training to promote 'safe sleep' and 'reduce the risk' messages, with the aim of reducing rates of sudden infant deaths in the borough. An additional training session will now take place on the 23rd July, 11.00-12.30pm at Linden Children's Centre. To book on this session, please email anna.lucas@homerton.nhs.uk

New Yoga Class for Pregnant Women

CLASSES ARE HELD AT LINDEN CHILDREN'S CENTRE,
TUESDAY'S AT 4.30-5.30PM,
ONLY £1 PER CLASS

TO BOOK WOMEN SHOULD CALL CARMEN ON [02030553333](tel:02030553333)



Upcoming Training	Date	Time	Venue	To book contact:
Responsive Feeding in Infant & Toddler	10/07/13	13:00-16:30	Homerton hospital	NutritionandDietetics@homerton.nhs.uk
Safe and Sound: safe sleep messages & reducing the risk of SIDs	23/07/13	11:00-12:30	Linden Children's Centre	anna.lucas@homerton.nhs.uk
Diabetes Education session	02/09/13	10:00-12:00	Ann Taylor Children's Centre	anna.lucas@homerton.nhs.uk
Cultural Awareness Workshop - The Irish Traveler Community	18/09/13	9:15 - 13:00	Tomlinson Centre	www.chscb.org.uk
Become a Breastfeeding Welcome Ambassador	23/09/13	10:00-13:00	Linden Children's Centre	Breastfeedinnowelcome@homerton.nhs.uk

This newsletter was produced by Anna Lucas, Public Health Coordinator for Children's Centres. Ideas, comments or contributions are welcomed: anna.lucas@homerton.nhs.uk

Appendix G

Feedback from staff about the newsletter

From: [REDACTED] at Homerton Hospital NHS Trust
Sent: 02 November 2012 2:13
To: Lucas Anna at Homerton University Hospital NHS Trust
Subject: RE: New Children's centre health newsletter for staff

Thanks Anna – this looks great. I will circulate to the paediatricians

[REDACTED]

Dr [REDACTED]
Consultant Community Paediatrician
Associate Medical Director
Children's Services, Outpatients and Diagnostics

Homerton University Hospital NHS Foundation Trust

[REDACTED]
[REDACTED]

.....
.....
From: [REDACTED] at Homerton Hospital NHS Trust
Sent: 06 November 2012 8:13
To: Lucas Anna at Homerton University Hospital NHS Trust
Subject: RE: New Children's centre health newsletter for staff

WONDERFUL – brought tears to my eyes! Hopefully seeing this will encourage contributions and suggestions from others! Truly WONDERFUL!

P

NB PLEASE USE MY NEW EMAIL ADDRESS philippa.kemsley@homerton.nhs.uk

[REDACTED]
*Childhood immunisation and public health specialist
Division for Children's Services, Diagnostics & Outpatients
Homerton University Hospital NHS Foundation Trust
203 Defoe Building
50 Hoxton Street
London N1 6LP*

T: [REDACTED]
M: [REDACTED]
E: philippa.kemsley@homerton.nhs.uk
www.homerton.nhs.uk

.....
.....

From: [REDACTED]
Sent: 02 November 2012 10:04
To: Lucas Anna at Homerton University Hospital NHS Trust
Cc: [REDACTED]
Subject: FW: New Children's centre health newsletter for staff

Dear Anna,

Congratulations! This is very good. Interesting, short, to the point, motivating, varied. Perhaps we could promote something on safe sleeping for infants (to prevent SIDS) in the next issue as well as something about the importance of timely immunisation of infants with the Whooping cough vaccine in the current outbreak.

Regards,

[REDACTED]

From: [REDACTED]
Sent: 05 February 2013 3:43
To: Lucas Anna at Homerton University Hospital NHS Trust;
Subject: RE: Children's Centre Health Update

Thanks Anna,

As usual it is quite impressive and informative, well done!

Good to see the launch of the Breastfeeding Friendly scheme on the front.

Regards,

[REDACTED]
Deputy Director of Public Health
Public Health City & Hackney
NHS NELC
Clifton House
75-77 Worship Street
London
EC2A 2DU
Tel: [REDACTED]
iose.figueroa@elc.nhs.uk

Appendix H

Common ground rules

It is particularly important to include ground rules on the following:

- Importance of attending all sessions
- Punctuality
- Importance and method of contact used by the health trainer, e.g. they will be telephoned if they have not turned up for a group session and will receive phone calls after the 8 sessions have finished up until the end of their pregnancy
- What to do if someone cannot come to a session
- Confidentiality
- Respect for other people's opinions
- Tolerance for disagreement
- Personal disclosure (people only saying what they feel comfortable with)

Appendix I Workplan

Workstream	Progress	Work to be done
27 month development reviews	<ul style="list-style-type: none"> • Awareness campaign – poster is now finalised awaiting leaflet draft. • I gained feedback from: <ul style="list-style-type: none"> ○ Parents - I ran a focus group with parents to gain feedback on the poster ○ OJ & muslim communities for cultural appropriateness ○ Health visitors – at team meetings 	Finalise promotional materials & arrange printing & distribution.
Common Assessment Framework & MAT	<ul style="list-style-type: none"> • CAF training – three delivered. • I attended CAF train the trainer course & supported the delivery of a training. • CCs keen to see how they can support HVs to be more effective in their feedback at MAT meetings & completing CAFs – supported arrangements for attending team meetings. • CAF leads from HV – arrange a meeting to support development 	Support training arrangements & continuing to help improve communication between health & CC staff.
Quarterly health data report	<ul style="list-style-type: none"> • Quarter 4 report in progress and yearly report. 176. 	Continue to improve the layout & ease of reading of the report.
Health promotion events	<ul style="list-style-type: none"> • Delivered events at [REDACTED]. • Upcoming event at [REDACTED] 	Prepare promotional materials
Breastfeeding & healthy weaning	<ul style="list-style-type: none"> • Agreed with [REDACTED] that she will take the lead on Breastfeeding for CCs. • Working to improving communication between the BfN & Children's centres by trying to develop an across Hackney approach to Breastfeeding to ensure support is available every day to women across the borough – a meeting has been arranged in May for CC lead, myself & [REDACTED] to discuss this plan. • Breastfeeding awareness week. • Breastfeeding training – short 2 hour training sessions for CC staff – asked CCs for feedback on whether they would like this training. 	To find an agreement between the CCs, BfN & midwifery to provide even coverage of BF groups over every day of the week.
Smoking	<ul style="list-style-type: none"> • 36 staff member have now been training in Level 1 smoking cessation training • I provided a stop smoking service at outreach events – made total of 9 referrals • Spoken at Health Visiting team and CC meetings about the Smokefree car & homes campaign. • First time tums group – Delivered information on the importance of not smoking during pregnancy and smoke free car and homes. • No Smoking Day –I provided drop-in stop smoking clinics for CCs who request it. • Delivered no smoking day materials to CCs 	Follow up impact of training
Prevention of sudden infant death	<ul style="list-style-type: none"> • Three 'Reduce the risk' training sessions are to be delivered by the [REDACTED] charity at [REDACTED] CC in May/June. Currently, 62 staff booked on. 	Send training reminder.
Accident prevention	<ul style="list-style-type: none"> • A&E diversion campaign 	
Healthy start for All	<ul style="list-style-type: none"> • Delivery of Healthy start for All stalls at each health event • Updating & reminding HVs & EYS at every chance about the scheme & current promotional priorities & materials available. • Arranging the promotion of Healthy start through programmes 	Work with public Health to promote the scheme effectively across Hackney & arrange promotional events.

	<ul style="list-style-type: none"> such as HENRY • Arranged CC lead - [REDACTED] 	
Teenage parents	<ul style="list-style-type: none"> • Working with Gloria the teenage pregnancy nurse to increase connections with young parents & connections with CCs – Spoken to CC staff and HV teams about [REDACTED] role & how to refer • I have flagged up with [REDACTED] that finding her referral form on the intranet is difficult & she is not clearly included in the midwifery referral pathway – suggested she meets with [REDACTED]. • Made arrangements for [REDACTED] to attend the young parents groups at [REDACTED] & [REDACTED] & the First time tums groups. • Ordered promotional materials designed for teenage parents • Raising awareness of the groups & training available for teenage parents. 	Explore how to increase teenage mum's awareness of the Breastfeeding welcome scheme & also to engage them with CCs & in training & volunteering opportunities.
Oral Health	<ul style="list-style-type: none"> • Worked with [REDACTED] Oral health team to ensure all CCs are receiving promotional material & baby toothbrushes. • Made arrangements for the team to attend health events • Arranged for three oral health promotion in the under5s to take place at a variety of CCs in May – 30 staff booked on so far. 	Make arrangements for oral health training to be provided for staff & parents as dental health champions.
Maternal obesity	<ul style="list-style-type: none"> • Ways to well-being group for obese pregnant women starts in May. • Meeting weekly with the dietitian to supporting the programme development including staffing, location, sessions materials etc. • Arranged to attend midwifery meeting to raise awareness • Gave a talk to pregnant women at first time tums (FTTs) group on the importance of physical activity during pregnancy and other health promotion topics i.e. healthy start • Provided the midwife running FTTs with worksheets and activities I have previously used with pregnant women and links for free resources. • I delivered a talk on 'obesity in pregnancy' at the obesity update study day – made links with a number of staff members including a physio who offered to support the ways to well-being group. • Pregnancy yoga class – agreed funding with public health for yoga teacher. Session to start at [REDACTED] in June. 	Support the continuing development & delivery of the 'Ways to well-being' group working with the dietetic team & health trainer. Work with midwifery to improve communication with CCs & engagement with health promotion. Prepare promo materials for pregnancy yoga
Signposting to information & services	<ul style="list-style-type: none"> • Health Update newsletter for Children's Centre staff has been delivered monthly. • Distributed to: Early year's staff, Learning trust, all CC health teams, public health, council health & well-being team, [REDACTED], [REDACTED], Voluntary staff including Breast feeding network & Bump buddies. • Feedback has been positive with contributions received from a variety of colleagues. • Made focus is ensuring staff are continuing to receive the newsletter & engaging staff in contributing to the newsletter. 	To determine if the format/style/content is appropriate & useful to staff.
Child obesity	<ul style="list-style-type: none"> • Raising awareness about how to raise the issue of child obesity with parents – article dedicated to this in newsletter • In discussions with dietetics to develop training for CC staff to help support raising the issue. • Delivered a talk on 'raising the issue of child obesity in the Under 5s' at the obesity study update at HUH. • Working with the HENRY team to support awareness among CC staff about the programme & recruit parents. 	Propose ideas for future training opportunities

	<ul style="list-style-type: none"> Obtained 'food smart' recipe booklets from C4L which have been distributed to all CCs with information about C4Ls new campaign. 	
Immunisations	<ul style="list-style-type: none"> Agreed that [REDACTED] will the lead for Immunisations In discussions about promoting imms through a promotional immunisations month campaign. 	Continue working with Imms team to support their agenda within CCs.
Child disability/special educational needs	<ul style="list-style-type: none"> Inviting the team to health events at CCs where they successfully signed up 9 families. Kept CCs up to date on events at [REDACTED]. Keep [REDACTED] up to date with what's available in CCs. 	Include article in next CC newsletter to raise awareness of the service.

Upcoming meetings

30th April: Early years and health meeting

7th May: Breastfeeding joint EYS and HUH meeting

8th May: Area A CCs- [REDACTED]

9th May: Health trainer induction day

11th: Health event at [REDACTED]

13th May: Running focus group at [REDACTED] evaluating longer term impact of 'Cook and Eat sessions'

14th May: Attend Midwifery team meeting

AppendixJ

Example of my notes written up following a meeting

██████████ HENRY dietitian 15.01.13

- ██████████ is organising the 'Obesity in children and young people update', which takes place at the Homerton education centre – 28th February
 - ██████████ asked if there are any topics I could talk on – I suggested talking about obesity in pregnancy, current research for lifestyle interventions and the current pilot at CC. Also, the feedback from the NCMP qualitative research evaluation.
- Training for CC staff on 'raising the issue of child obesity'
 - Discussed whether this should be a series of talks, a half day training or a talk delivered at CC team meetings.
 - I will put together a summary of topics to talk about and we will discuss further the right approach.
- HENRY
 - Discussed my support with the delivery of the programme within CCs.
 - Advertisement of the programme among families
 - Coordinated Hackney wide so that the start dates programmes are spread out over the year across the borough.
 - Supporting staff to refer parents – training previously mentioned
 - What is the cost for a large Banner – I will check costs of the healthy start banner.
 - Discussed idea of supporting HENRY to be culturally appropriate – might be something we can think of once the programme is up and running possibly run OJ community specific HENRY and also HENRY for Turkish families.

Actions points

1. Details of CC Quarterly leads forum
2. Ideas for training
3. Points to talk about at obesity update talk
4. Date for diary – Obesity update talk 28th February Education centre, the Homerton.
5. Find out how to obtain a banner for HENRY like Healthy start

Appendix K

NUTRITIONAL ENQUIRIES THAT AROSE FROM UPBEAT GROUP SESSIONS AND SENT TO DIETITIAN

To: [REDACTED]
Subject: Dietary questions

Hi [REDACTED]

The women from my group today would like some advice if possible about different types of yoghurt. They are unsure whether choosing probiotic yoghurts like Activia or Yakult is more beneficial to them than the standard low fat yoghurt?

One of the women has an iron deficiency which she takes tablets for but sometimes she says she craves Supermalt because of its high iron content although is now aware of just how much sugar it contains. Are there any other similar drinks that are not as sugary but contain iron. She has tried light Supermalt but does not taste good.

Thanks Anna

To: [REDACTED]
Subject: questions from upbeat session

Hi [REDACTED],

Hope all is well and thanks for the information you gave me last week I fed that back to the ladies today and they found it useful. One more question this week regarding yoghurts.

One of the ladies mentioned she had an Actimel yoghurt every day because she doesn't like milk so she is aware she needs to still get calcium daily from somewhere. Is Actimel a good choice?

Also, Greek yoghurt was mentioned and I explained that low fat Greek yoghurt should be fine for Upbeat but that I would check with you?

Also mentioned was crisps. Two of the women have small children so crisps are always in the house so they are often tempted to snack on crisps themselves. We thought about alternatives they could have but they did question me about the different types of crisps and which ones are better for example the 'baked' walkers crisps. I suggested checking the nutritional labels before buying them to compare the content of fat/sugar. I wondered is there any other advice about crisps I should give them?

Thanks Anna

Appendix L

Use of professional log for reflections

Early reflections

Date	Competency	Experience	Work completed	Reflection/analysis	Next steps
12/04/11	2.1e (2) 3.3a	Islington – Data collection	Facilitated a 1 hr focus group with delegates from the Health promotion in Practice training	Lovely group, some interesting and novel comments. The group appeared to enjoy the process of talking about their examples of using the new skills they had learnt and hearing other professionals use the skills.	Data to be transcribed and added to analysis.
15/04/11	1.1c	Meeting with workplace supervisor to discuss my role.	Made arrangements for course supervisor visit. Discussed my research project, how I may be able to do something related to my role. Looked at my current responsibilities & possible areas for progression within the role.	Although carrying out research based around my job may be appealing time wise the restrictions on topic etc. are not so. Was positive to hear there are opportunities for me to get involved in a training role.	Need to consider the practicalities of recruiting participants & where I would be able to carry out research that interests me. To focus on my project aims and consider process outcomes.
18/04/11	1.2a,b 2.1e	Weekly Upbeat meeting	Meeting focused on changes to the study's protocol as the study moves into the main trial phase. Discussion of the suggested changes made to the health trainer manual	Was glad to hear the changes I suggested have been agreed by other members of the team & will be included in the adaptations.	To keep up to date with the progress of the manual.
21/04/11	1.2 c	Review of Upbeat Health trainer session manual	Reviewed changes made to handbook & changes to the content some of which I had produced like information on eating out/ordering takeaway.	Having been working on the materials for the past year it was useful to see all the adaptations & additions & I feel they will positively affect the sessions.	To get to grips with the new materials ready for when the ethics approval is received. & put the changes into practice.

Later reflections

Date	Competency	Experience	Work completed	Reflection/analysis	Next steps
23/01/13	1.1c	HUH – Attended Solihull training	The training offered a useful framework for thinking about children’s emotional health & well-being & practical tools for working with families.	For me the most relevant aspect of the training was learning about containment because I rarely work with families directly but I saw how this approach could be adapted to working with colleagues & supervising others.	Put this skill into practice
24/01/13	1.1b	LMU – meeting with supervisor	We discussed a number of areas of my work according to the agenda I had written and I received some advice & feedback on the projected timetable I had completed for my work.	At first, I did not realise how important it would be to get feedback from my supervisor on my supervision plan however I received some useful advice & guidance which I feel will help me stick to this timetable.	Put next supervision date in the diary
24/01/13	4.3a, b	LSHTM – Grant application arrangements	Having had a conference call with the team I started attending to the action points I had agreed to deliver on, such as finding partner organisations interested in being involved with the recruitment of participants.	As a group we are trying to jointly put together the application components & previously I have felt I was given too much of the work to do alone however this time I made sure I only took on areas I felt I could deliver within the timeframe.	Update team on progress & ask for advice when necessary.

Appendix Consultancy in Health Psychology

Appendix A

Request for consultancy

Dear All,

I have been given your email addresses by [REDACTED] and told that you may be interested in gaining some research experience within my team here at London School of Hygiene and Tropical Medicine.

I am a Research Fellow here at the school working on a number of NIHR funded child obesity research projects including an evaluation of the National Child Measurement Programme and the development of an electronic tool for the management of child obesity in primary care.

We may have a number of opportunities for people interested in the field of child obesity including writing systematic literature reviews, assisting with grant applications and pilot intervention development work.

If any of this sounds of interest to you, I would be grateful if you are able to get in touch and we can arrange for an informal chat to decide the best way to move forward.

Many thanks for your time

[REDACTED]

[REDACTED], PhD
Research Fellow
Department of Non-Communicable Disease Epidemiology
London School of Hygiene and Tropical Medicine
Keppel Street
WC1E 7HT

[REDACTED]

Appendix B

15.06.13

Meeting minutes from initial consultancy meetings

Meeting 1: [REDACTED]

- Client gave a brief description of the department. He relayed that there may be an opportunity to work on child obesity-related research, funded by National Institute of Health Research (NIHR).
- Client described some current and upcoming projects around child obesity within the department as well as ideas for future projects where funding would need to be applied for.
- I described my education, experience and skills including interests in obesity, previous work as a qualitative researcher and what I could contribute to the projects
- Client said he was pleased I had so many skills and he felt they would fit well with the work the department does.
- Client asked me how much time I had available to offer and for how long. I suggested I could work on a part-time basis which could currently be 1-2 days a week possibly for the 1.5 years of time which may be dependent on any changes to job circumstances.
- I was set an initial project to look at the requirements for a first stage grant application to BUPA which includes a one page outline of a research proposed for a child obesity lifestyle family intervention for South Asian families.
- Client explained that if I can give this a go first then we can meet later to discuss further work on projects.
- Client told me to meet with Catherine to receive some of the preliminary work that has been carried out so far on the research.

Meeting 2: [REDACTED]

- Client 2 outlined that the department had received funding from the Department of Health to expand the evaluation of the National Child Measurement programme.
- As part of this, they have included an additional 2 Primary Care Trusts for the questionnaire surveys and they have also been asked to perform some simple qualitative work with the parents of children identified as overweight/very overweight in the NCMP.
- Client 2 explained they needed support to deliver the qualitative element of the evaluations.
- Client 2 explained that I should meet with her and the research time and asked for to email her my availability and she would arrange.
- Client 2 advised that I should only take on work from Client 1 if I have the time to do so and not to feel pressured into saying yes to everything.

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Appendix C

Checklist #3. Planning a Contracting Meeting (Block, 2012, page 98)

1. What imbalance do you expect in the responsibility for this project? Do you think the client will want to treat you as the expert and give you 80 percent of the responsibility? Or will the client treat you as a pair-of-hands and keep 80 percent of the responsibility?
2. What do you want from the client?
 - What are your essential wants?
 - What are your desirable wants?
3. What are you offering the client?
 - Technically?
 - Personally?
4. What do you think the client might want? List all possibilities.
 - Technically?
 - Personally?
5. Are the key clients going to be in the room?
 - Who can make a decision on proceeding with this project?
 - Who will be strongly affected by this project?
 - Who is missing from the meeting?
 - What are their roles? (For example, get some action on the problem started, actually implement the outcome of your consultation; they have the best information on the problem.)
6. What resistance do you anticipate?
7. What are the conditions under which it would be best not to proceed?

Appendix D

CONTRACT FOR HEALTH PSYCHOLOGY SERVICES TO ASSIST THE LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICAL (LSHTM)

Contracting Client: London School of Hygiene and Tropical Medical, Department of Non-communicable Disease Epidemiology, [REDACTED] Senior Lecturer in Non-communicable Disease Epidemiology

Consultant: Anna Lucas, Trainee Health Psychologist

NATURE OF SERVICES

To work on an NIHR funded project on the assessment and management of childhood obesity which. The project aims to build a coherent programme of clinical and public health research within a patient perspective that significantly contributes towards improving the treatment of childhood obesity in the NHS.

To support the development and delivery of the project's evaluation according to agreed outcomes. The first project to be the Study A: National Child Measurement Programme (NCMP) Evaluation Study. To run from November 2011 until August 2012. Reporting to study team via main researcher [REDACTED] Health, Behaviour Research Centre, Department of Epidemiology and Public Health, University College London. The aim of this study is to help us to learn more about parents' views of the NCMP and the impact of this feedback on the family's lifestyle.

The second project to be Study B: An electronic tool for the management of child overweight. To run from April 2012 until August 2012. Reporting to study team via main researcher [REDACTED], Department of Non-communicable Disease Epidemiology, LSHTM. The aim of this study is to develop and evaluate a brief evidence-based electronic tool to improve the management of obesity by front-line staff.

Aims:

To work with the study teams to complete the project ensuring the completion of tasks within the specified timeline and reporting to [REDACTED], the co-chief investigator and public health lead on the programme.

To meet regularly with study team to generate solutions to any problems that are identified and becoming familiar with staff and local practices, supported by [REDACTED]. The Trainee Health Psychologist undertakes to keep a reflexive journal to evaluate and learn from the processes of the project.

METHOD AND TIME FRAME

The Trainee Consultant will be working as part of the Department of Non-communicable Disease Epidemiology one to two days a week from June 2011 until August 2012. She will work one to two days a week as needed depending on need and her commitment to her post.

For study A this will involve carrying out individual interviews with study subjects (parents of children in the overweight or obese categories) and analysis of the data. For study B to be involved in the qualitative process evaluation, drafting interview topic guides, providing information on the feasibility and acceptability of the intervention, possible reasons for its success or failure and contextual factors influencing these. This will involve carrying out individual interviews with study subjects and participating health professionals. Analysis of qualitative data and presentation of data, drafting of reports and manuscripts. To liaise with study team and other collaborators, including GP surgeries.

CONSULTANT REQUIREMENTS

An identified link person from LSHTM ([REDACTED]) in which she will be working to aid communication, provide requested information, help problem solve barriers.

The consultant will work primarily from home but when necessary will be provided with a desk.

COST

Travel expenses over and above the normal daily journey from home to base will be reimbursed by the completion of the relevant expenses form.

CODE OF CONDUCT

The consultant will carry out the service in accordance with the British Psychological Society and Health Professions Council guidelines and standards.

INTELLECTUAL PROPERTY

The consultant shall be named on any publications arising from her work.

CONFIDENTIALITY

During the course of the services the consultant may have access to, gain knowledge of or be entrusted with information of a confidential nature. In signing this contract, the consultant agrees, unless expressly authorised by a senior authorised person to so, will not disclose to

any unauthorised person or organisation any such confidential information. The consultant agrees to store and process information in accordance with the Data Protection Act 1998.

Signature of Client

..... Date:

Signature of Consultant

..... Date:

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Appendix E

Consultant evaluation form

Client organisation: Department of Non-communicable Disease Epidemiology, London School of Hygiene & Tropical Medicine

Consultant name: Anna Lucas

Contract period: From: June 2011

To: March 2013

Reviewer name: [REDACTED]

Reviewer title: [REDACTED] Senior Lecturer in Non-communicable Disease Epidemiology

Rating:

1 – Strongly Agree

2 – Agree

3 – Disagree

4 – Strongly Disagree

N – Not Applicable

Using the ratings defined above, please let us know if you agree or disagree with the following statements:

The consultant...

KNOWLEDGE and SKILLS

Demonstrated the technical skills needed to complete the job or project	1	2	3	4	N
Performed satisfactorily	1	2	3	4	N

PRODUCTIVITY

Met project goals as scheduled	1	2	3	4	N
Made the job or project a success	1	2	3	4	N

COMMUNICATION

Provided timely communication	1	2	3	4	N
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Was a good listener		1	2	3	4	N
Returned phone calls/e-mails promptly	1	2	3	4	N	
Was available to the staff when needed		1	2	3	4	N
Was easily accessed by my staff		1	2	3	4	N

I N T E R A C T I O N

Worked well with key players in the organisation		1	2	3	4	N
Was able to work as part of a team		1	2	3	4	N
Provided updates and information as the job or project progressed		1	2	3	4	N
Reacted well to constructive criticism		1	2	3	4	N

O V E R A L L P E R F O R M A N C E

Delivered work/projects on time		1	2	3	4	N
Demonstrated dependability		1	2	3	4	N

F O R Y O U R N E X T P R O J E C T . . .

I would hire this consultant again		1	2	3	4	N
I would recommend this consultant to Colleagues		1	2	3	4	N

Thank you for taking the time to complete this evaluation form.

Do you have any other feedback you would like to add?

Signature of Client/Reviewer

..... Date:

Appendix Teaching and Training Case study

Appendix A

Knowles' theories (Knowles, 1980) can be stated with six (6) assumptions related to motivation of adult learning:

1. Adults need to know the reason for learning something (Need to Know);
2. Experience provides the basis for learning activities (Foundation);
3. Adults need to be responsible for their decisions on education; involvement in the planning and evaluation of their instruction (Self-conceptualization);
4. Adults are most interested in learning subjects having immediate relevance to their work and/or personal lives (Readiness);
5. Adult learning is problem-centered rather than content-oriented (Orientation);
6. Adults respond better to internal versus external motivators (Motivation).

Appendix B

Learner Profile

Background of Learners	21 years + (some mature students) Female/Male split 80/20 Diverse ethnicity Foreign students with English not their first language Educated to degree level
Prior Experience	BSc Psychology Interest in Health Psychology
Learners' Objectives	To successfully gain an understanding of the contribution of mass media to health promotion and increase their learning towards the overall module's learning outcomes which are to: 1. Explain the historical development, the current status and the priorities of health psychology; 2. Understand the main biological systems that influence health; 3. Understand the main social and economic influences on health; 4. Evaluate health psychology approaches to promoting improved health.
Learners' Motivation	To successfully pass the module assessments which include: 1. A coursework essay of approximately 2000 words. 2. An unseen examination covering the core topics for the module. 3. Attendance at classes
Success Factors	Connect with the information and relate it to their own experiences
Technology	Learners will have access to Weblearn an online area that holds information about their modules including the module handbook and slides from each session.
Learning Strategies	As they are a small teaching group various learning styles can be accommodated using visual aids and participation from students and activities.
Support	Students will have the opportunity to ask questions during the teaching session.
Desired competencies	The module aims are: <ul style="list-style-type: none"> • To introduce health psychology as an academic and professional discipline; • To place health psychology concepts and methods meaningfully within a broad framework including biological mechanisms that mediate psychological influences on health, social and economic factors that influence health and healthcare, and working within multidisciplinary settings; • To explore the application of psychology to health outcomes and processes; • To critically assess the limitations of psychological approaches to health.

Appendix C

Teaching session overview	
Course title	Health Psychology
Type of postgraduate qualification	<ul style="list-style-type: none"> • Master of Science (MSc) • Stage 1 qualification in Health Psychology • Accredited by the British Psychological Society
Institution	London Metropolitan University
Module	Context and Application in Health Psychology PYP013C
Subject area	The role of mass media in health promotion
Session delivery information	Week 8: City campus, Calcutta house 1 hour delivery – no break
Equipment/resources	Projector set up DVD recording equipment
Method	Lecturing with use of visual aids and various class participatory activities.
Lecture outline	This session looks at the double-edged sword of health-related coverage by the mass media and its role in reporting risks to our health. The outcome of different media reporting styles e.g. health scares such as the MMR vaccine or coverage of celebrity's choosing not to breastfeed. The use of mass media for health promotion at community, national and international level and the psychological models underlying campaign strategies. Topics for discussion include the media's responsibility in its portrayal of health-related matters and whether lay people can use this information to help them make informed choices about the way they live their lives.
Learning outcomes	<ul style="list-style-type: none"> • Know the types and roles of mass media • Understand the use of media in advancing public health goals • Appreciate the complexity of communicating about health through mass media • Analyse the contribution of mass media to health promotion at community, national and international level. • Evaluate the beneficial and harmful impacts of mass media.
Recommended reading	<ul style="list-style-type: none"> • Corcoran, N. (2007) <i>Communicating Health: Strategies for Health Promotion</i>, Sage: London • Hastings, G., & MacFadyen, L. (2002). '<i>Controversies in tobacco control: the limitations of fear messages.</i>' <i>Tobacco Control</i>, 11, 73-75 • Hilton, S., & Hunt, K. (2010). <i>Coverage of Jade Goody's cervical cancer in UK newspapers: a missed opportunity for health promotion?</i> <i>BMC Public Health</i> 10:368 • Hodgetts, D., & Chamberlain, K. (2006). <i>Developing a critical media research agenda for health psychology.</i> <i>Journal of Health Psychology</i>, 11 (2) 317-327 • Hodgetts, D., & Chamberlain, K. (2006). <i>Media and health: a continuing concern for Health Psychology</i>, <i>Journal of Health Psychology</i>, 11 (2) 171-174 • Lynch, B.M., & Dunn, J. (2003). '<i>Scoreboard advertising at</i>

	<p><i>sporting events as a health promotion medium.</i>' Health Education Research, 18, 488-492.</p> <ul style="list-style-type: none"> • NHS Choices, <i>Behind the headlines</i>: http://www.nhs.uk/News/Pages/NewsIndex.aspx • Thorson, E. (2006). <i>Print news and health psychology: some observations</i>. Journal of Health Psychology 11(2) 175-182
Evaluation design	One page evaluation form with ratings and open questions.

Appendix D

Assessment strategy (*taken from the module handbook*)

The module will be assessed in three ways:

1. A coursework essay of approximately 2000 words. This assesses in-depth understanding, argumentation and evaluation of an important broad-ranging issue in health. Students will choose an essay title from two or more options that relate to key issues or areas of material covered by the module.
2. An unseen examination covering the core topics for the module. Students will be required to select one question out of four and complete all questions for that answer, written in short answer format.
3. In addition students will be assessed on attendance at all classes. Students are expected to attend all scheduled sessions. If for legitimate reasons (eg sickness) a student cannot attend all then up to 2 sessions may be missed.

The following aspects of students' coursework essays and examination essays will form the basis of assessment:

1. Synthesis of appropriate material to provide an answer to the question, rather than simply presenting relevant material.
2. Comprehensive coverage of the area, showing clear evidence of reading beyond the lecture notes and core texts and knowledge of the current literature.
3. Depth of understanding in respect of conceptual and empirical bases of theoretical explanations, methodological issues as they relate to interpretation of empirical evidence and theory building, historical background to theoretical explanations, and broader context of the area of study in respect of its history and relationship with cognate areas.
4. Critical evaluation of the material, demonstrating knowledge and understanding of conceptual and/ or methodological criticisms, and an understanding of alternative perspectives and current controversies.
5. Development of argument, using psychological theory and empirical evidence to debate issues and support a case, rather than simply presenting derivative arguments.
6. Structure and organisation of material.
7. Clarity and coherence.

Essay title:

How does culture impact on health? Why might health psychologists need to take this impact into account? *(This essay question was developed by Anna Lucas)*

Appendix E



LEARNING OUTCOMES

- Know the types and roles of media
- Understand the use of media in advancing public health goals
- Appreciate the complexity of communicating about health through mass media
- Analyse the contribution of mass media to health promotion at community, national and international level.
- Evaluate the beneficial and harmful impacts of mass media.

MASS MEDIA: DEFINITION

'A **tool** for the transfer of information, concepts, and ideas to both general and specific audiences.'

'Any type of broadcast, printed or electronic communication medium that is sent to the population at large'

(Corcoran, 2007)



Television

- Reach
- Costs
- Greater audience involvement
- Complementary messages portrayed in parallel to TV

Newspapers

- Level of detail
- Shelf life

Leaflets, brochures, and posters

- Readily found
- Infrequently evaluated

Internet

- Massive increase in Internet users
- Firmer autonomous control

Smart phones?



Smart phones:

Phone applications

Examples:

- monitor your daily levels and effectively manage your diabetes.
- An interactive tool to provide bowel cancer data for your area and to highlight variations in mortality and incidence across the UK.

THE ROLE OF MASS MEDIA

Mass media campaigns have, in societies like our own, a key role to play in:

- o educating (knowledge gap)
- o shaping public relations (agenda setting) public focus perceived importance
- o cultivation of shared public perceptions



THE INFLUENCE OF MASS MEDIA

- ⦿ There has been a change in where people obtain their information about health and health matters
 - Health and illness information is found increasingly in newspapers, magazines and on television.
- ⦿ The media are powerful in setting agendas
 - issues that are reported in the media are viewed as important and worthy of public discourse
- ⦿ The mass media play a major role in circulating both expert and lay accounts to the public
 - (Hepworth & Featherstone, 1998).

IMPORTANT SOURCE OF INFORMATION?



- ⦿ Some 80% of the population say that the media are their most important source of health information
 - Do you agree? Where do you go for health information?

Obesity

- ⦿ What does it look like?
- ⦿ Who has it?
- ⦿ Why do they have it?

AIDS/HIV

- ⦿ What does it look like?
- ⦿ Who has it?
- ⦿ Why do they have it?

REASONS TO PAY ATTENTION TO MEDIA REPRESENTATIONS OF HEALTH AND ILLNESS

1. They affect individuals' beliefs and understandings about health and illness, which in turn can affect a diverse range of issues such as risk perception and health behaviours.
2. Representations create and reproduce meaning and thus can influence, for example, individuals' attitudes towards people with disease and how certain subgroups of the population are viewed.
3. Representations of health can mediate individuals' lived experience of physical sensations and their subjectivities.

MEDIA EFFECTS

The mass media are capable of facilitating short-term, intermediate-term, and long-term effects on audiences.

- **Short-term**
 - exposing audiences to health concepts
 - creating awareness and knowledge
 - altering outdated or incorrect knowledge
 - enhancing audience recall of particular advertisements or promotions.
- **Intermediate-term** - include all of the above, as well as
 - changes in attitudes
 - Changes in behaviours
 - perceptions of social norms
- **Long-term** - incorporate all of the aforementioned tasks, in addition to
 - focused restructuring of perceived social norms
 - maintenance of behaviour change
- Evidence of achieving these three tiers of objectives is useful in evaluating the effectiveness of mass media.

THE TROUBLE WITH ADVERTISING

- ⊙ Junk food
- ⊙ Alcohol
- ⊙ Tobacco
- ⊙ Celebrity endorsement
- ⊙ Sponsorship and 'product placement'

HOW HAS THIS PRODUCT BEEN PORTRAYED?



MASS MEDIA CAMPAIGNS

- ◉ Promote healthy behaviours and discourage unhealthy behaviours
- ◉ Large amounts of money, time, and effort
- ◉ Designed, developed and targeted to meet specific objectives.
- ◉ Success and effectiveness varied & difficult to measure



Just Eat More
(fruit & veg)



- ⦿ What can health promotion campaigns employing mass media campaigns achieve?
 - Think of a health campaign and consider how it may have influenced your view, thoughts, behaviour and actions.

PROBLEMS WITH HEALTH MESSAGES IN THE NEWS

- ⦿ Focus on 'newsworthy' stories about health services rather than public health
- ⦿ Unbalanced reporting of health risks
- ⦿ The media can be very persuasive i.e. That wrong eating habits are right and natural
- ⦿ The media can create anxieties about being deprived if we don't have what "everyone else" is having"
- ⦿ Tends to focus on blame, individualistic models
- ⦿ Not the 'real' picture - not include influence of social & environmental factors
- ⦿ The priorities and decisions of policy-makers are often shaped by what they see on television, hear on the radio, and read in the general and specialist press.
- ⦿ NHS Choices, *Behind the headlines*: <http://www.nhs.uk/News/Pages/NewsIndex.aspx>

HEALTH SCARES

'BSE will kill millions'

'MMR causes autism'

'HPV vaccine causes severe side effects'

'Low fat yoghurt eaten during pregnancy causes asthma'

'Oral contraceptive causes blood clots'

● Unbalanced reporting of health risks

- What impact does this have on the individual behaviour?
- How effective do you think fear is as an appeal used in health promotion?

THE 'GOODY' EFFECT

- Fall in acceptance of screening, particularly women 25-35yrs
- Some laboratories are reporting a 20% increase in cases, others as much as 50%.
- May encourage parents to get their teenage daughters vaccinated against HPV
- However, there was a failure of newsprint coverage of her illness and death to include basic information on the signs and symptoms of cervical cancer, common risk factors for the disease, and the possibility of protecting young women.
- Sun newspaper launched a campaign to get the government to reduce the age screening starts to 20. The Department of Health decided not to lower the screening age, facing uproar from the public.
- Jade Goody had a cancer type called adenocarcinoma which a cervical screen is not used to detect.

DRAMATIC OR TRAGIC EVENT REPORTING

- Mass media will publicise dramatic or tragic issues
- Unplanned media coverage can lead to incorrect information being publicised and can result in serious negative consequences in terms of health outcomes
 - Health promoters are unable to control the message being portrayed

WHEN MASS MEDIA WORKS..

- ⦿ Wide exposure is desired.
- ⦿ The timeframe is urgent
- ⦿ Public discussion is likely to facilitate the educational process
- ⦿ Awareness is a main goal.
- ⦿ Media authorities are 'on-side
- ⦿ Accompanying back-up can be provided on the ground.
- ⦿ Long-term follow-up is possible
- ⦿ A generous budget exists.
- ⦿ The behavioural goal is simple
- ⦿ The agenda includes public relations

CONT'D

- ⦿ Campaigns are most likely to influence behaviour change if their focus is on behaviours that are already receptive to change (Atkin, 2001)
 - ⦿ Simple messages 'Put babies to sleep on their backs'
 - ⦿ Simple messages change behaviour if enabling factors already exist.
 - For example, a message encouraging five fruit and veg a day, individual's behaviours could be influenced if:
1. **A habit was already established** - eating fruit and veg regularly - indicating a likelihood that such a person would hold positive beliefs positively disposed towards the healthy-promoting message.
 2. Given that the person already eats fruit and veg regularly, there would be **no major changes or implications of increasing the number of pieces of fruit and veg.**

THE MEDIA CANNOT

- ⦿ Teach skills
- ⦿ Change behaviours in the absence of other enabling factors
- ⦿ Cause attitudinal changes if the new message challenges basic belief
- ⦿ Present complex information e.g. the relative risk of different types of fat in the diet.

PROBLEMS WITH HEALTH MESSAGES IN THE NEWS

- ◉ Focus on 'newsworthy' stories about health services rather than public health and unusual stories
- ◉ Unbalanced reporting of health risks
- ◉ The media can be very persuasive i.e. That wrong eating habits are right and natural
- ◉ The media can create anxieties about being deprived if we don't have what "everyone else" is having
- ◉ Tends to focus on blame, individualistic models Not the 'real' picture - not include influence of social & environmental factors
- ◉ The priorities and decisions of policy-makers are often shaped by what they see on television, hear on the radio, and read in the general and specialist press.
- ◉ NHS Choices, *Behind the headlines*: <http://www.nhs.uk/News/Pages/NewsIndex.aspx>

- ◉ As the World Health Organisation has stated, 'changes in individual behaviour would seem to require both the provision of accurate information and the reduction of misinformation' (WHO 2002: 27).'

MEDIA RESPONSIBILITY

- ◉ Should they present a greater variety of body shapes and sizes in photos, in the music industry, as television presenters etc.?
- ◉ Should they assist people with an influence on young people (such as parents, teachers) from making weight an issue?
- ◉ Should they provide 'healthy' role models only?
- ◉ Should they glamorise celebrities who lose weight quickly after having babies?

IN SUMMARY

- ④ Mass media cannot convey complex information or messages and consequently cannot be used to teach skills which may facilitate behaviour change.
- ④ Can reach a wide audience, but it is not possible to provide tailored messages which can be adapted to individual levels of knowledge or to each health belief held.
- ④ Impossible to provide 1:1 support which may further facilitate behaviour change.
 - However, campaigns have more recently included helpline numbers and website addresses, which can increase the level of support available.

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Appendix F

Session plan

<p>MATERIAL RESOURCES: Projector for Powerpoint presentation Paper and pens Handouts Recording equipment</p> <p>PHYSICAL RESOURCES Room booked</p> <p>LECTURE OUTLINE: This session looks at the double-edged sword of health-related coverage by the mass media and its role in reporting risks to our health. The outcome of different media reporting styles e.g. health scares such as the MMR vaccine or coverage of celebrity's choosing not to breastfeed. The use of mass media for health promotion at community, national and international level and the psychological models underlying campaign strategies. Topics for discussion include the media's responsibility in its portrayal of health-related matters and whether lay people can use this information to help them make informed choices about the way they live their lives.</p> <p>Session topic: Mass media and health promotion</p> <p>Pedagogy: To provide evidence of delivering an intellectually stimulating talk reflected through the feedback. To encourage participation through small group exercises and discussion and invitations to share related experiences.</p>		
	CONTENT	DURATION
ARRIVAL	Welcome in students, signing of register, arranging seating, setting up video recording equipment and seating arrangements for the observer.	
INTRODUCTION:	<p>Introduction</p> <ul style="list-style-type: none"> • Explain who I am - brief outline of my position, training and experience. <p>Explain aims and learning outcomes of the session</p> <ul style="list-style-type: none"> • Attempt to engage students in the topic and the objectives of the session. <p>Detail session structure</p> <ul style="list-style-type: none"> • I will explicit and signpost what I am doing, preparing students for how I will be delivering the session and for what the session will involve of them as learners. 	4 mins
What is mass media/ types of media:	<p>Open question to the group, 'What is mass media?'</p> <ul style="list-style-type: none"> • Attempt to engage the group using prompts and encourage curiosity in the topic, assess current knowledge <p>Different means of communication</p> <ul style="list-style-type: none"> • Provide descriptions of the types of media available, how information is transferred and the positives and negatives of each. 	10 mins

The role and influence of mass media:	Exploring the effects of mass media and limitations of using mass media <ul style="list-style-type: none"> Provide learners with an understanding of the short, medium and long terms effects of media on audiences 	4 mins
ACTIVITY 1:	Aim: For students to understand the influence media can have on representations of health and illness. <ul style="list-style-type: none"> Students asked to join together in small groups of 3 or 4 and discuss their thoughts on the following: <u>Obesity and AIDS/HIV</u> <ol style="list-style-type: none"> What does it look like? Who has it? Why do they have it? Walk around the groups to check their understanding of the activity and answer any queries. Each group will be asked to feedback their thoughts to the class Provide summary of their thoughts and relay some observations to them about why they may have answered the way they have. 	10 mins
ACTIVITY 2: Describe the products advertising campaign	Lead in to the activity with an outline of some examples of the problems with advertising. Whole group activity: Ask the group to offer suggestions on how the products pictured in the slides have been portrayed through adverts? <ul style="list-style-type: none"> Unpick their answers or provide prompts if no one answers 	8 mins
Mass media health campaigns	Provide brief outline of what mass media health campaigns are, the costs, effectiveness.	3 mins
ACTIVITY 3: Guess the health campaign?	Whole group activity: Ask the group to offer suggestions on what the campaign posters shown on the slides represent. <ul style="list-style-type: none"> Prompt learners if unsure and ask how effective they think the campaign might have been in their opinion to engage learners fully with the task. At the end I will summarise the contribution mass media can have for the development, delivery and impact of health campaigns. 	5 mins
Problems with health messages in the media	Display examples of media reports that have caused health scares <ul style="list-style-type: none"> Ask students if they heard these headlines and whether they feel it influenced their knowledge or beliefs. Explain the impacts these health scares have had on the public in the short and long-term. 	4 mins
When mass media works	Ask about the content of the lecture while it is taking place <ul style="list-style-type: none"> Make links with the previous activities 	3 mins
What mass media cannot achieve:	Give description of the limitations of mass media <ul style="list-style-type: none"> Check students understand by asking them what the reasons are for these limitations. 	2mins
Activity 4: Media	Encourage group to ask questions and aim to inspire them to	3 mins

responsibility	follow up this topic further	
SUMMARY	<ul style="list-style-type: none"> • Re-cap on the key points from the session • Questions and Answers 	2 mins
RECOMMENDED READING	<ul style="list-style-type: none"> • Provide suggested reading handout 	58 mins total
EVALUATION:	Hand out evaluation forms: Ask group members how they feel the session has gone for them, how they are feeling, what worked well, not so well and looking forward to completing the programme with them.	3 mins

Appendix Teaching and Training Evaluation

Appendix A

Observer's report

Anna Lucas – Mass Media and Health Lecture, Teaching Observation Feedback (25/11/11)

- Good eliciting from the group and nice slides.
- The groups seems to be a bit slow to warm up today so maybe allow them more time to come up with ideas.
- Very nice slides with photos of products and product information – supports what you're trying to get across very well.
- A good amount of information on both sides of the argument.
- You could have related 'hot' fear messages to what we already know from the Health Belief Model. .
- You could have referred to research on media intervention. Also look more into Health Psychology – your references are good so you just need to have made the links clearer.
- See also my observations from your other teaching session for notes on style, pace etc.

Anna Lucas - Culture and Health Lecture, Teaching Observation Feedback (22/10/11)

- You have a good voice and give a clear introduction to the lecture at a good pace. Your questions to the group are effective.
- This teaching room is difficult as it's an odd shape but try not to stand in front of your slides!
- The slides themselves are clear and well presented, I like your use of pictures.
- Don't be shy about talking about definitions of race or ethnicity, it's important to be clear. I like the example of modesty across cultures but maybe you would have got more out of it if you had pursued it with the group (which is very mixed). It's always good to pursue examples with them and get students involved in discussion early on in the session so that they start off engaged and stay that way. You can also encourage them to give you examples and don't be afraid to wait for what might feel like a painfully long time while they come up with some examples – it's probably not as long as you think!
- You link your lecture well into the wider module as well as health psychology in general.
- The group task is good, and I like that you came out from behind the desk for feedback. I like your example of establishing a different cultural context like going smoke free at work, having a fitness culture in the office or a drinking culture at work.
- I like the group work on interventions for HIV – you gave the group a good length of time in which to complete it and your follow up slides with the 'answers' were very useful.

Appendix B

Lecture feedback form: The role of mass media in health promotion

The session helped my understanding of the topic?

Strongly disagree 1 2 3 4 5 Strongly agree

Was the content interesting?

Very uninteresting 1 2 3 4 5 Very interesting

Did you find the lecture useful?

Not useful 1 2 3 4 5 Very useful

The material was presented in a manner that facilitated understanding?

Strongly disagree 1 2 3 4 5 Strongly agree

What are the most memorable pieces of information you will take away from this lecture?

Would you like to add anything about the coverage or focus of the lecture?

Is there anything else you would like to say about the session?

Appendix C

CENTRE FOR ACADEMIC PRACTICE THE UNIVERSITY OF WARWICK

<http://www2.warwick.ac.uk/services/ldc/resource/evaluation/tools/self>

Questions for problem solving

- What would make the situation better?
- What do you want? What else?
- How do you feel about the situation?
- What is most important to you in this situation?
- How do you want to feel about this situation?
- What assumptions are you making about the situation?
- What assumptions are you making about someone else in this situation?
- What could be the cost to you of not solving this problem?
- What does your response to this situation tell you about yourself?
- How do you know this?
- What could you do differently?
- Where could you get help to improve this situation?
- What is positive about the situation?
- What is the most radical thing you could do?
- What is the simplest thing you could do?
- What don't you know about the situation?
- What is the relationship between how things are now and how you want them to be?
- What about this situation would you most like to change?
- What would you like someone else to do differently?
- How does this situation affect you personally?
- Can you explain that further?
- If you get what you want what will this achieve for you?
- What do you need to do first?
- What is stopping you?
- What do you want instead?
- What will happen if you are not successful in getting what you want?
- Why do you believe what you want is reasonable?
- Why do you believe what you want has value?
- Why are you the best person to be doing what you are thinking of doing?
- What about this situation causes you most anxiety or distress?
- If you are successful how will you feel?

Questions to prompt learning from experience

- What would have made this better?
- What did you want? What else?
- How did you feel about the situation?
- What from this experience do you most appreciate about yourself?
- How do you feel about this situation now?
- What result did you want?
- What could you learn about yourself from this experience?
- How do you know this?
- What could you do differently next time?
- What do you remember thinking but not saying?
- What did you feel but not reveal?
- What is the most radical thing you could have done?
- What is the easiest thing you could have done?
- What don't you know about the situation?
- What can this experience tell you about how you 'see' the world?
- What could you definitely not have done?
- What might you have invented or imagined about the situation?
- What surprised you about the situation?
- What surprises you about it now?
- What else?

Appendix Interventions in Health Psychology

Appendix A

N.B Sections in italics were not included in the questionnaire when given to parents

Physical activity questionnaire

For your child to reach the recommended level of physical activity your child needs to do at least 60 minutes (1 hour) of physical activity every day, which should be a mix of moderate-intensity aerobic activity, such as fast walking, and vigorous-intensity aerobic activity, such as running.

(HBM questions)

1. Do you feel your child's level of physical activity can affect their general health?
YES/NO
2. Do you believe physical activity is affecting your child's general health? YES/NO
3. What are the benefits of you being more physically active with your child?
4. What are the issues with you being more physically active with your child?
5. Do you feel confident you know how and have the available resources to ensure your child is physically active? YES/NO
6. What do you expect would be the result of you being more physically active with your child?

(Transtheoretical model)

1. Are you interested in trying to be more physically active with your child/children?
YES/NO (*Pre-contemplation*)
2. Are you thinking about how you could be more physically active with your children this summer? YES/NO (*Contemplation*)
3. Are you ready to plan how you will be more physically active with your children?
YES/NO (*Preparation*)
4. Are you in the process of trying to be more physically active with your children?
YES/NO (*Action*)

5. Are you already physically active with your children? YES/NO (*Maintenance*)

Appendix B

Parent and child walk scheme

Ethical, practical and safety issues to consider before intervention delivery

1. Completion of Outdoor Health Questionnaire by all children no matter of age.
2. Completion of walk registers at start of each walk detailing all children no matter their age.
3. Reflect on previous written risk assessments of each walk to ensure the risks posed were considered in light of not of just adults attending the walks but children.
4. Check with Human Resources that all walk leaders have completed the Criminal Bureau Checks.
5. Agreement from walk leaders that they feel the walk routes have not changed considerably since the last risk assessments were carried out and for all the walks to be advertised to parents and children.
6. High Elms park walk is a particularly child friendly walk with wetland centre/café at end of route.
7. Obtain details of all primary school head teachers – speak with council.
8. Ensure the intervention is authorised by relevant parties – provide manager with intervention plan and request feedback from other team members in case I have missed any concerns or areas that need further consideration.
9. Health and safety – Check with walk leaders they feel confident to complete an accident report form when necessary and confirm which leaders are up to date with their first aid training qualification.
10. Staffing – As there is likely to be an increase in walkers attending walks I will deliver another Walk Leader training day to provide current walk leaders with more support over the summer holidays.

179.

Appendix C

Key features to inform the design of the intervention

Barriers to engaging in physical activity:

- finding activities suitable for the whole family, activities too expensive, poor weather conditions, no activities locally and distance from home and inflexibility of structured physical activity in terms of the time's its available.

Encouragement and information reinforcing the benefits would likely support them to reduce the cons of changing their behaviour.

Motivations to be more active as a family:

- child's weight a motivator and cue to be more active
 - parent's wanting their children to spend less time indoors playing on computers or watching television.
 - Summer holidays an opportunity to engage families together
- 180.

More support to perceive flexibility in completing physical activity as a family and more understanding of the health benefits.

Possible intervention issues

- Children can only attend with an adult to supervise them and the walk leader made this clear to the parents.
- Pushchair friendly walks are available from the programme but parents will still need to choose the right walks for their needs.
- Extra volunteers needed to support the walks so groups can separate into different speeds.

Appendix D



Health Improvement Service

Beckenham Clinic
14 The Crescent
Beckenham BR3 1DU
Tel: 020 8662 6692
Email: bro-pct.bromleywalks@nhs.net



26 June 2012

Take a parent for a walk this summer

Dear (School)

Bromley Healthcare's 'Walking for Health' programme is inviting hundreds of children to 'take a parent for a walk' over the Summer holidays.

We hope to team up with a number of schools to trial the idea of encouraging parents to go on our free, organised walks to enjoy the area's beautiful parks and countryside.

Walking for Health in Bromley has volunteers leading weekly walks across the borough, which is a fun way of carrying out more healthy exercise. The walks are graded according to length, speed and gradient to cater for different levels of fitness. Everyone is welcome with routes for wheelchair and pushchair users.

Under the 'take a parent for a walk' initiative, pupils will be given leaflets about the walks on offer. Then, if a parent takes them on one of the walks, the child will receive a certificate and be entered into a prize draw with the chance to win a pair of junior binoculars.

Walking has a wide range of health benefits, both physical and psychological. It can:

- **Reduce blood pressure**
- **Reduce risk of heart disease**
- **Control and reduce weight**
- **Improve psychological wellbeing**

- **Reduce the risk of bowel and colon cancer**

We would be very grateful if schools agree to help us in this way to encourage more pupils and parents to carry out healthy exercise. We think parents will enjoy bringing their children on one of the 8 routes we have across the area. It's an easy way to keep the kids occupied for a morning or afternoon, it's a good way to stay healthy and it's free.

Our volunteer walk leaders are very friendly and welcoming and can share a lot of information about wildlife and local heritage that people, young and old, always find interesting.

Some parents may be taking time off work over the holiday period so we hope this will offer them something to do with the children. We also hope many parents will enjoy the walks so much; they may want to continue with the walks when the children go back to school. It's a great way to meet new people and make new friends.

Many young people are increasingly aware of the need to stay fit and healthy so we think this will appeal to them as well. It's the first time we've tried promoting our walks in this way but hopefully it will be a great way to introduce families to our walking programme.

If you would like to take part in the programme please contact Anna Lucas, Health Development Advisor on 02086626684 or Anna.Lucas@Bromleyhealthcare-cic.nhs.uk.

Appendix E

This summer Bromley Healthcare are inviting children to 'take a parent for a walk'



Our Health Walks are a great way to make sure children have lots of fun and get their **60 active minutes** every day

At the end of a walk, Walk Leaders will be giving children a **certificate** for taking part and a **medal sticker**

Health Walks are at various locations across the borough's green spaces. Walks are **free of charge** all you need are a pair of trainers or comfy shoes and if it's raining, grab a coat & wellies.

Let's get active



Take your parent for a walk this summer



Dear Parent/Guardian,

Bromley Healthcare's 'Take a parent for a walk this summer' initiative invites you to join our Health Walks programme.

Our Health Walks are situated at various locations across the borough's green spaces. Walks are free of charge and they take place weekly, Monday to Friday.

Our Health Walks are a great way to make sure children have lots of fun this summer and get their 60 active minutes every day.

Walking has a wide range of health benefits, both physical and psychological. It can:

- **Reduce blood pressure**
- **Reduce risk of heart disease**
- **Control and reduce weight**
- **Improve psychological wellbeing**
- **Reduce the risk of bowel and colon cancer**

There is no need to book, just turn up at the meeting location as indicated on the programme. We do ask that you wear suitable outdoor clothing on the walks (such as trainers or wellingtons). Please also remember to bring a bottle of water and sunscreen on sunny days.

At the end of the walk, the Walk Leaders will be giving children a medal sticker for taking part. Also they will receive a certificate when back at school and entered into a prize draw to win a junior pair of binoculars each time they go on a Health Walk.

We hope that you will enjoy exploring our Health Walks with your child and that you have a very happy and fun-filled summer holiday.

Yours sincerely,

Walking for health in Bromley



WALK	DAY/TIME	MEETING PLACE	DESCRIPTION	♿	🍴	♿	🚶	👴	👵	⚠️	⬆️	⬆️	🚧
St Paul's Cray	Monday 9.45am	In car park at top of Cotmandene Crescent	In Scaisbury Nature Reserve. Approximately 2.5 miles. 60 minutes.	✓				✓	✓	✓	✓	✓	
Sundridge Park	Monday 10.00am	Prince Frederick Pub 31 Nichol Lane BR1 4DE	Starting and finishing in Kings Meadow Park and entails eight steps over a bridge. Approximately 1.5-2 miles. 45 minutes.	✓	✓		✓	✓	✓	✓	✓	✓	
Sundridge Park	Monday 10.40am	Minster Road entrance to Kings Meadow Park	Suitable for older people and those less steady on their feet. Approximately 0.25 mile. 20 minutes.	✓	✓	✓	✓		✓	✓			
High Elms Country Park	Tuesday 10.00am	In the main car park by the notice board	Walk through High Elms Country Park. Approximately 2-3.5 miles. 60-90 minutes.	✓	✓			✓			✓	✓	✓
Darrick & Newstead Woods & Tugmutton Common	Wednesday 2.00pm	Outside the cricket pavilion Tugmutton Common off Starts Hill Road	Starts at Tugmutton Common, continues through Darrick & Newstead Woods. 2.5 miles. 60 minutes.					✓			✓	✓	✓
Kelsey Park & Harvington Woods	Thursday 10.00am	At Kelsey Park Cafe by Friends of Kelsey Park notice board	Starting and finishing in Kelsey Park. Approximately 1.5 miles. 45-60 minutes.	✓	✓			✓			✓		
Jubilee Park Petts Wood	Friday 2.00pm	Terrace Lane Crest View Drive Petts Wood	Through Jubilee Country Park. Approximately 2.5 miles. 60 minutes.	✓	✓			✓	✓		✓		

Our walks are led by qualified walk leaders and provide a friendly and sociable atmosphere in which to enjoy some of our beautiful open spaces.

Walks are suitable for all ages and abilities and take place every week except Bank Holidays or in cases of severe bad weather.

There is no need to book – just turn up at the location and times listed above. Sorry, no dogs please.



- Toilets
- Refreshments
- Accessible
- Strollers
- Woods
- Follows footpath
- Tarmac surface
- May be muddy
- Some inclines
- Some declines
- Crossing

At Macmillan Cancer Support we know that when you are living with or recovering from cancer, physical activity can help make a positive change in your life. If you or someone you know is affected by cancer, we can help. Phone 0800 808 0000 or visit www.macmillan.org.uk We couldn't provide the support we do without our supporters. To get involved, call us on 0300 1000 200.

The Ramblers are Britain's walking charity, dedicated to promoting and supporting walking up and down the country, whether you want to walk on your own or tackle longer walks with a group. Ramblers can provide information and inspiration to help you on your way. www.ramblers.org.uk



What is a health walk?

A health walk is a regular, weekly walk led by a trained, volunteer leader.

You can take things at your own pace, starting slowly and building up gently. It's wonderfully social too – you can spend quality time with family and friends – and who knows, even make some new ones.

What do I need?

Just a good pair of shoes, which you probably have anyway. Anything that's comfortable, supportive and doesn't give you blisters. You can move more freely in loose-fitting clothing, and it's better to wear several thin layers rather than heavy, bulky clothing.

If you're going to be outdoors for a while, remember to take some water. And don't forget to be prepared for the British weather – if it looks like rain, a waterproof or umbrella will be very handy, and a sun hat and cream are a good idea in summer.

Just be at the meeting point 5-10 minutes before the scheduled start time (see overleaf). When you first join a walk as you will need to complete a simple health questionnaire.

Why should I come along?

If you still need convincing, here are a few things that walking can do for your health:

- Help your heart and lungs work better
- Lower your blood pressure
- Keep your weight down
- Lighten your mood
- Keep your joints, muscles and bones strong
- Increase 'good' cholesterol.

Who are we?

We are Walking for Health, an England-wide network set-up to get you walking and get you healthy. We know that getting active can be difficult. But we're here to help. You can take part in our free short walks near to where you live, at a pace that works for you. It's a great way to stretch your legs, explore what's on your doorstep, and make new friends.

For over 12 years, we've helped thousands of people like you discover the many benefits of regular group walks. From reducing stress, to losing weight, to sharing laughs, **Walking for Health has something for everyone.**

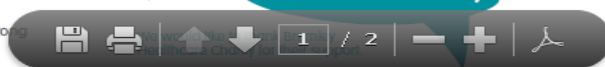
The walks themselves are run by all kinds of folk, including local councils, the NHS, charities and voluntary groups, while the network as a whole is managed in partnership by the **Ramblers** and **Macmillan Cancer Support**. For more details and to find your local scheme visit:

www.walkingforhealth.org.uk

For more details about your local health walks scheme, please contact our coordinator Sam on the details below.

Sam Walsham
07800 578095
samwalsham@hotmail.com

Find us on:
www.facebook.com/walkingforhealthinbromley



Appendix G

Family Adventure Walk & Picnic

Join us for an exciting day of events including a fun family walk through Marvels Wood, energetic games & a yummy, healthy family picnic.

Everyone will be given a goody bag with a free gift for children and parents!

Appendix H



Beckenham Clinic
14 The Crescent
Beckenham
Kent
BR3 1DU
Tel: 020 8662 6692
www.bromleyhealthcare.org.uk

New scheme: Take a parent for a walk this summer



Dear Walk Leaders,

Bromley Healthcare's 'Walking for Health' programme is inviting hundreds of children to 'take a parent for a walk' over the Summer holidays. We have teamed up with twelve schools encouraging children and parents to go on our walks to enjoy the area's beautiful parks and countryside.

Under the 'take a parent for a walk' initiative, pupils have been given flyers about the walks on offer and parents received information from schools. If a parent takes them on one of the walks, the child will receive a certificate presented when back at school and be entered into a prize draw with the chance to win a pair of junior binoculars.

It's the first time we've tried promoting our walks in this way but hopefully it will be a great way to introduce families to our walking programme.

Included in this pack are medal stickers, which you can give to any child who attends your walk. We would also like to know which schools children are from to be able to present them with certificates. Therefore, when OHQs are filled out please ask them to write their school name clearly at the top of the OHQ.

Yours Sincerely,

Anna Lucas

Health Development Advisor

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