FLORA FIT STREET:
A QUALITATIVE EVALUATION

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Acronyms and Abbreviations

CP NDC  Clapham Park New Deal for Communities
CPP      Clapham Park Project
FFS      Flora Fit Street

Ethics & funding

Research governance approval for this study was obtained from the Research Development Centre for Primary, Community & Social Care (based at Southwark PCT, which deals with research governance clearance for research carried out in Greenwich, Lambeth, Lewisham or Southwark NHS Primary Care Trusts; and the study was approved by the St Thomas' Hospital Research Ethics Committee (ref 04/Q0702/141).

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EXECUTIVE SUMMARY

Flora Fit Street

Flora Fit Street was a community based healthy living initiative carried out in Clapham Park, south London during 2004-5, in a private public partnership between Flora (Unilever) and Clapham Park New Deal for Communities. It was designed to be a 12 week intervention for participants.

Flora Fit Street offered free local testing of physiological indicators of health, including blood pressure, blood glucose, cholesterol, weight, BMI and self-reported indexes of dietary choices and physical activity. It also offered free, one to one health advice, and optional consultations with diet and exercise specialists.

Participants in Flora Fit Street had the opportunity to take part in a range of exercise, activity and cookery classes, at no or reduced cost, at local venues throughout the community.

Participants in Flora Fit Street were invited to take part in follow-up testing to monitor their progress. After 6 months, attrition from the project was notable: declining from 199 to 35 participants actively engaged in Flora Fit Street, and consenting to take part in the associated scientific study of the effects of the scheme.

Flora Fit Street was widely considered a success for the community in Clapham Park, with significant improvements in the mean blood cholesterol levels and ‘healthy’ food choices made by participants. However, there were inequalities in the uptake of the scheme, with an under recruitment of men and older people.

Qualitative evaluation of Flora Fit Street

To further understand participation, and to reflect on the potential weaknesses of Flora Fit Street as a model for healthy living initiatives, it was important to talk to participants and non-participants about their experiences and perceptions of the scheme. A sample of 16 people was recruited.

Purposive recruitment strategies sampled men and women from the two major ethnic groups in Clapham Park; white (white British) and black (black British, black African and black Caribbean). Flora Fit Street participants were recruited through direct mail and telephone calls, on the basis of prior consent into the scientific study and from available contact information they had already provided to evaluators. Non-participants were recruited through Clapham Park New Deal for Communities outreach work.
The sample took part in structured, individual interviews, on the telephone or face to face. Questions covered topics of personal reasons for attending or not attending healthy lifestyle initiatives; perceptions of own health and wellbeing; and perceptions of problems and opportunities for making sustainable healthy changes. Interviews were transcribed and analysed thematically.

The analysis explored themes of patterns of participation, barriers and facilitators of participation and participant-identified inadequacies of the scheme. On the basis of this analysis, recommendations are made for designing and delivering similar healthy lifestyle community schemes.

**Patterns of participation: how well did Fit Street fit?**

People who fully participated in the testing, diet changes, exercise increases and follow-up sessions were predominantly satisfied with their experiences at Flora Fit Street and identified a range of convenient features of the scheme that demonstrated a good ‘fit’ with their daily lives prior to the scheme and their level of motivation and commitment to making healthier changes.

People who partially participated in the scheme, receiving tests and advice, and making some diet changes but not attending exercise classes were predominantly satisfied at their own experiences at Fit Street, but identified a less good ‘fit’ between the scheme and their daily lives and competing time commitments.

People who participated in an introduction to Fit Street but then dropped out of the scheme were predominantly unimpressed and uninterested in Fit Street after attending one session, and identified a poor ‘fit’ between the scheme and their preferences and capacity to join an organised scheme.

People who did not participate in any aspect of Fit Street were predominantly positive about the concept of a community healthy living initiative but identified large differences between what such a scheme could offer and what would suit their needs and preferences.

**Barriers and facilitators to participation: what made it easier and harder to choose Fit Street?**

Work, childcare, studying, old age, lack of knowledge about community venues, fear of travelling locally alone, physical disabilities and perceptions of the scheme being inadequate to meet complex health needs, or to educate the already health conscious were identified as barriers to participating.

Community venues, access to free testing outside of GP surgeries, free classes, discounts for activities, health advice, dietary plans and guidance,
individualised information, motivation and encouragement from staff, and support through coordinated advice and opportunity to follow the advice were all identified as facilitating participation.

**Recommendations for delivering healthy lifestyle community schemes**

Healthy lifestyle community schemes need to have a broader understanding of convenience in terms of times of day and the choice of appropriate venues. Daytime sessions are better for the retired and those with school aged children, but evenings are better for those who work and do not have younger children that require childcare supervision. People with children require childcare facilities or the opportunity to get involved alongside their children.

Venues need to be clearly identifiable, easy to access by public transport and safe walking and driving routes, and accessible for a range of physical abilities.

Services need to offer advice and information to a range of detail and complexity, and provide self-developing routes to motivation and encouragement to ‘take up and keep up’ healthy lifestyle changes.

Interventions that are planned to be short term need to build in aftercare style information and development as part of the programme, contributing to sustainable healthy changes.

Diet advice may be more accessible for local populations, because it is easier to deliver information and integrate guidance into everyday life. Exercise advice may be less well adhered to or engaged in, but with appropriate support can generate remarkable changes in self-perceptions of fitness and functional ability of participants.

**Reducing inequalities in uptake**

More gender and age specific sessions may help to improve the ‘fit’ between the potential benefits of attending healthy lifestyle initiatives and the perceptions of under-represented groups, and encourage men and older people to identify that such schemes are ‘for people like me’.
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INTRODUCTION

1.1 Introduction

This report summaries a qualitative evaluation of the Flora Fit Street community based health living initiative. Participants and non-participants in the scheme were interviewed after the end of the initiative. These interviews have been thematically analysed, and the findings are presented here in three main areas: patterns and levels of adherence to the scheme; barriers and facilitators to participation; and recommendations for improving provision of similar schemes.

1.2 Healthy lifestyle choices

The rise in lifestyle and personal choice health agendas has developed in parallel to the shift in the population disease burden from acute communicable diseases to chronic illnesses. Government policies and targets, such as those outlined in “Choosing Health” place emphasis on lifestyle behaviour choices, including physical activity, smoking cessation and food consumption, reducing the burden of preventable disease and reducing health inequalities through community action and widening access to environments that support making healthy lifestyle choices (Department of Health, 2004).

Chronic illness is associated with and can be 'promoted' by behaviour choices, and the health promotion agenda has largely responded with educational individualised responsibility approaches to preventing and reducing the disease burden (Cockerham 2005, Archer 2000).

However, approaches to promoting healthy choices that are exclusively health advice, in absence of consideration of social norms and environmental constraints are “unlikely to produce behaviour change” (McNeill, Kreuter & Subramanian, 2006).

Health behaviour choice represents both agency and structure. Agency is an individual’s capacity, disposition and preference for determining their behaviour; structure is the context, resources and social factors that ‘contour’ such choices (Sibeon, 1999). If health behaviour choice is the product of choosing (agency) from what is available (structure), health promotion interventions need to consider provision of both education to enhance personal agency and shared resources to enhance public health structures.

The emphasis on choosing 'from what is available' has led some critics to suggest a top-down emphasis on the need for structural and social changes is required for effecting individual benefit (Cockerham 2005) and avoiding the
"upward conflation" of individual determinants of generating healthy behaviour choices (Archer 2000).

1.3 Healthy lifestyle interventions

Healthy lifestyle interventions, that is projects and initiatives that go beyond national health promotion campaigns and provisions, have been reported as broadly successful, but are not without criticism.

Healthy lifestyle interventions have resulted in weight loss (Fontaine, 1999); improved health related quality of life scores (Kerse, 2005); stress management (Johnson-Kozlow, Sallis & Calfas, 2004); improvements in diabetes outcomes (Liberopoulus, 2006); improvements in dietary intake (Sartorelli, 2005); and body image and general wellbeing (Hausenblas, 2006).

However, a lack of sustainable change across health dimensions has been strongly criticised (Morgan 2005, Harrison 2004); along with related doubts about cost-effectiveness of localised, short-term interventions (Hagberg, 2005; Sevick 2000). Schemes have also come under criticism for lack of participation across the community and not providing the breadth of services needed to fulfil the needs of a diverse population both culturally and geographically. Uptake rates in interventions can be quite low and skewed; reflecting, rather than challenging, local health inequalities (Bandesha, 2005; Harrison, 2005).

1.4 Flora Fit Street: A community based healthy living initiative

Flora Fit Street (FFS) was a public private partnership between Clapham Park New Deal for Communities (CP NDC) and Flora. It was organised within and for the community living in Clapham Park, a neighbourhood in Lambeth, south London. The neighbourhood has the dubious honour of being the location for Toynbee's "Hard work: Life in low paid Britain" investigation and social commentary into minimum wage work and social deprivation (Toynbee, 2003), and has been "largely forgotten over the last 20 years' (Clapham Park Project, 2006).

FFS was located within community venues across the neighbourhood and aimed to be accessible to all parts of the local population. The project utilised social marketing strategies and employed the skills of a PR firm to encourage awareness and uptake of FFS, and ran for over a year. The project was informed by a behaviour change model, and offered multiple points of entry, multiple modes of participation and multiple opportunities of advice and support.
Participants started FFS by attending a Healthy Heart MOT, which was an initial heart health check-up offering a combination of physical health tests (results fed back in the same session), questionnaires to assess participants’ well-being, 20 minutes consultation with a health professional and further optional consultations with exercise and nutrition specialists. The MOTs included tests of blood cholesterol, blood glucose, blood pressure, body mass index and resting heart rate, as well as self-reported smoking, self-reported activity (Seven Day Activity Recall) and self-perceptions of health (SF-36).

During the 12 weeks after the initial MOT, participants were able to take part in local activities, including exercise and dance classes; physical activity groups such as power walking; cooking classes; and use a discount card for individual activities such as swimming, cycling and skating. Nutrition and exercise specialists were available monthly for on-going advice, and the FFS office was open during the week to respond to enquiries. After 12 weeks, participants were invited back to an ‘exit’ MOT (3 month follow-up), offering the same tests as before, with further advice and feedback about their progress. After another 12 weeks, participants were again invited back to FFS for another MOT (6 month follow-up).

Participation rates fell across duration of the project, and the following figures reflect only the participants who consented to take part in the scientific study (see Figure 1).

**Figure 1 : Declining participation across 6 months of FFS**

<table>
<thead>
<tr>
<th>Session</th>
<th>Number of Participants</th>
<th>Male</th>
<th>Female</th>
<th>Average age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Heart MOT</td>
<td>199</td>
<td>73</td>
<td>126</td>
<td>38.9</td>
</tr>
<tr>
<td>3 month follow-up</td>
<td>111</td>
<td>33</td>
<td>78</td>
<td>40.2</td>
</tr>
<tr>
<td>6 month follow-up</td>
<td>35</td>
<td>10</td>
<td>25</td>
<td>43.9</td>
</tr>
</tbody>
</table>

At 3 and 6 months the return rates of men and women were similar, compared to the initial intake, and those who returned or left FFS did not significantly differ by ethnicity, weight, BMI, blood pressure, physical activity or smoking status (Taket, Crichton and Gauvin, 2006). However, by 6 months there were significant differences in the age of the sample compared to the baseline session; younger people were more likely to drop-out from the scheme. Figure 2 outlines the key achievements measured at 3 and 6 months.
Figure 2: Achievements at 3 and 6 months

<table>
<thead>
<tr>
<th>3 month follow-up compared to baseline</th>
<th>6 month follow-up compared to baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.9% reduction in mean cholesterol</td>
<td>13.2% reduction in mean cholesterol</td>
</tr>
<tr>
<td>5.7% reduction in mean glucose level</td>
<td>No significant changes</td>
</tr>
<tr>
<td>Significant improvements on 2</td>
<td>Significant improvement on 1</td>
</tr>
<tr>
<td>dimensions of SF-36: Bodily Pain and</td>
<td>dimension of SF-36: Role Limitation</td>
</tr>
<tr>
<td>General Health Perception</td>
<td>Due to Physical Problems</td>
</tr>
<tr>
<td>45% of participants increased their</td>
<td>52% of participants increased their</td>
</tr>
<tr>
<td>healthy food choices; 41% of</td>
<td>healthy food choices; 43% of</td>
</tr>
<tr>
<td>participants decreased their non-</td>
<td>participants decreased their non-</td>
</tr>
<tr>
<td>healthy food choices</td>
<td>healthy food choices</td>
</tr>
</tbody>
</table>

“Overall, for the participants who stayed with the program, these findings suggest that FFS has had a positive and sustained effect on their health.”

Flora Fit Street Final Report

1.5 Evaluating Flora Fit Street

The physiological and health impacts of FFS are reported in detail elsewhere (Taket, Crichton and Gauvin, 2006) where challenging areas for the FFS project were identified, including the under-attendance of men and older people initially, and overall retention of participants, as well as positive areas that need greater understanding, such as factors that encouraged uptake and retention of the project. In order to explore inadequacies, barriers and facilitators to benefiting from community healthy living interventions, a qualitative evaluation of FFS was also carried out.

The qualitative evaluation aimed to explore the experience of participation in FFS, and assess the project from a lay perspective. A 'lay' sense of healthiness and wellbeing includes social and environmental dimensions in addition to the absence or presence of medical conditions (Grant, 2005). Health can also be conceptualised as an "achievement" for the individual, and healthiness and 'health consumption' can contribute to one's social identity (Scambler, Olsen and Griva, 2004; Blaxter 2004). Therefore this evaluation considers themes of motivation experiences and change, allowing the interviewees to define and describe their own perceptions of the project and the impact it may or may not have had on their lives and their health.
There was a high drop-out rate from FFS and it is important to consider those who left the project before completing as well as those who were retained. Also, the project was aimed at the whole community and so as part of a critique of its success it is important to consider those who self-selected themselves out of the scheme, as well as those who participated. Therefore, the qualitative evaluation includes people who took part to varying extents in FFS.
METHOD

2.1 Recruitment

Recruitment strategies aimed to sample both those who had taken part in FFS (participants) and those who had not, but who had been aware of FFS, that is had actively decided not to take part (non-participants). As the qualitative study aimed to use a small sample size, consideration was given to stratifying the ethnicities included in the following recruitment methods. Reflecting the major ethnic groups of the locality, there are two ethnic groups used here: white (White British, White Irish and White other) and black (Black British, Black African, Black Caribbean and Black other).

To recruit FFS participants, letters were sent to the people who had consented into the FFS evaluation study and according to the FFS administrative records had also arranged a follow-up session. The FFS database recorded ethnicity, and only self-reported white or black participants were approached. There are many ethnicities in south London and with a small sample size it was considered necessary to deliberately sample from only the major ethnicities in the local community. The letter outlined what the evaluation was about and invited people to call or email the research team to arrange an interview. The response rate was very low (4%).

Where available in the FFS database, the research team telephoned previous participants to follow-up the invitation letters and information, leaving up to two answerphone messages when calls were not answered. Some of the previous participants who did answer responded quite negatively, indicating fatigue from participating in a long-term study and disapproval of continuing evaluation when the scheme had been concluded. There was also some confusion about the role of the FFS administrative team and the independent evaluation team. The response rate remained low, and there was a high rate of incomplete or out of date information in the telephone contact details of the previous participants (around 15%).

Finally, follow-up letters were sent approximately 6 weeks after the first letter and with re-drafted information and style of presentation, excluding anyone who had already responded that they would be unwilling to take part. The response rate remained low, but increased to 10%.

For non-participants, a leaflet was designed that asked whether they had been aware of FFS but decided not to take part, outlining the purpose of the evaluation and the need to include people who had declined to join in FFS. With support from CP NDC, these leaflets were distributed at community venues throughout Clapham Park. The leaflets invited people to contact the research team directly, or to give their contact details to a named
representative at CP NDC, who would in turn pass the information on to the researchers. After receiving more written information about the evaluation, around half of those who had initially shown interest in the study actually took part in interviews.

All interviewees were offered £20 gift voucher on completion of the interview.

### 2.2 Sample

There were 16 interviewees, 5 male, 11 female. Their ages ranged from 25 to 85, the average age for white interviewees (50.4 years) was higher than the average age for black interviewees (44.9 years).

#### Figure 3: Gender, ethnicity, age and adherence classification of interviewees

<table>
<thead>
<tr>
<th>ID</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Age</th>
<th>Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Female</td>
<td>Black</td>
<td>44</td>
<td>Post-introduction decliner</td>
</tr>
<tr>
<td>B2</td>
<td>Female</td>
<td>Black</td>
<td>65</td>
<td>Partial adherer</td>
</tr>
<tr>
<td>C3</td>
<td>Female</td>
<td>White</td>
<td>56</td>
<td>Post-introduction decliner</td>
</tr>
<tr>
<td>D4</td>
<td>Male</td>
<td>White</td>
<td>85</td>
<td>Pre-introduction decliner</td>
</tr>
<tr>
<td>E5</td>
<td>Female</td>
<td>Black</td>
<td>37</td>
<td>Partial adherer</td>
</tr>
<tr>
<td>F6</td>
<td>Female</td>
<td>Black</td>
<td>37</td>
<td>Completer</td>
</tr>
<tr>
<td>G7</td>
<td>Female</td>
<td>White</td>
<td>40</td>
<td>Completer</td>
</tr>
<tr>
<td>H8</td>
<td>Male</td>
<td>Black</td>
<td>53</td>
<td>Post-introduction decliner</td>
</tr>
<tr>
<td>I9</td>
<td>Female</td>
<td>Black</td>
<td>31</td>
<td>Completer</td>
</tr>
<tr>
<td>J10</td>
<td>Female</td>
<td>White</td>
<td>36</td>
<td>Partial adherer</td>
</tr>
<tr>
<td>K11</td>
<td>Female</td>
<td>White</td>
<td>48</td>
<td>Completer</td>
</tr>
<tr>
<td>L12</td>
<td>Female</td>
<td>Black</td>
<td>56</td>
<td>Completer</td>
</tr>
<tr>
<td>M13</td>
<td>Male</td>
<td>White</td>
<td>37</td>
<td>Partial adherer</td>
</tr>
<tr>
<td>N14</td>
<td>Male</td>
<td>White</td>
<td>25</td>
<td>Partial adherer</td>
</tr>
<tr>
<td>O15</td>
<td>Male</td>
<td>Black</td>
<td>36</td>
<td>Completer</td>
</tr>
<tr>
<td>P16</td>
<td>Female</td>
<td>White</td>
<td>76</td>
<td>Pre-Introduction decliner</td>
</tr>
<tr>
<td></td>
<td>11 female</td>
<td>8 black</td>
<td></td>
<td>Av. Age = 47.6 years*</td>
</tr>
<tr>
<td></td>
<td>5 male</td>
<td>8 white</td>
<td></td>
<td>6 completers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 partial adherers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 decliners</td>
</tr>
</tbody>
</table>

*average female age = 47.8 (exclude pre-introduction decliners = 45 years); average male age = 47.2 (exclude pre-introduction decliners = 38 years).

### 2.3 Interviews

Those recruited into the evaluation were asked to take part in one structured interview. Interviews were designed to take no more than about half an hour, and interviewees could decide whether to take part over the telephone or in
person. Face to face interviews were carried out in the CP NDC meeting facilities. All interviews were taped and transcribed for analysis.

Five themes were identified when designing the structured interview schedules:
1. motivation to attend or not attend healthy lifestyle initiatives
2. perceptions of own health and wellbeing
3. motivation to improve own health and wellbeing
4. perceptions of barriers and paths to improving or protecting own health and wellbeing
5. motivations to sustaining current health practices and perceptions of likely maintenance of health practices

These themes were developed to be framed in ways that were meaningful to both those who had and had not participated in FFS, in a series of structured topic areas.

For participants the interview schedule covered 6 main areas:
1. What were your expectations of FFS and why did you decide to go?
2. What were your experiences at the first MOT and how did you react to the results of the tests?
3. Which classes/ activities did you join in, and what motivated you to take part and continue with the activities?
4. What changes did you make to your diet following the advice of the experts at the MOTs?
5. What your experiences at the follow-up MOT, and how did you react to the follow-up set of tests?
6. Whether or not the changes you made to your diet and activity level has been and will be sustainable

For non-participants the interview schedule covered 3 main areas:
1. How did you hear about FFS and why did you decide not to go?
2. What would have needed to have been offered by FFS to interest you in participating?
3. In what ways do you live a health lifestyle (or not)?

2.4 Analysis

Interviews were analysed using thematic analysis techniques. In response to emerging themes in the data, themes were explored around patterns of attendance, social identity and identifying with the perceived target market of FFS, perceptions of support and barriers to using FFS, and suggestions for ways to improve similar schemes.
RESULTS

3.1 Levels of adherence

In the original study design two divisions of participation were proposed: participants and non-participants. Recruitment strategies and participant information sheets outlined that participants had attended the first and follow-up MOTs and had participated in classes and or activities offered by FFS; and that non-participants had been aware of the scheme but had decided not to join in FFS.

During the course of the interviews it became apparent that the interviewees did not fit neatly into these two groups, and that people identified with participant or non-participant recruitment materials for the qualitative study in inconsistent ways. The first aspect of analysis of the interviews therefore considered the extent to which the interviewees had participated in and adhered to FFS.

Four criteria were used, based on factual statements of participation across the duration of FFS; attendance at the first MOT, following dietary advice provided at the introductory session, joining and attending activities or classes, and attending a follow-up MOT. On this basis three categories were derived: completers, partial adherers and non-participants.

Completers attended both the introductory and follow-up MOTs, made changes to their diet and physical activity. Partial adherers attended both the introductory and follow-up MOTs, reported making some changes to their dietary intake, but did not participate in the classes and activities provided with the FFS scheme. Non-participants did not participate in classes or activities and did not attend any follow-up MOTs. Some reported attending the introductory session and subsequently declining all other aspects of FFS, whilst others effectively declined prior to the introductory sessions and did not attend any aspect of the scheme, even through they were aware that FFS was being run in their area. Pre-introduction decliners were notably older than the post-introduction decliners in this sample.

Men and women are represented in each of the groups outlined here and the interviewees' narratives have been analysed and presented within these group definitions in the following sections. For clarity, 'interviewees' is used as a term to refer to the people who took part in the qualitative study and 'participants' or 'non-participants' refer to taking part in the Flora Fit Street scheme itself.
Figure 4: Gender and age, by adherence group

<table>
<thead>
<tr>
<th>Group</th>
<th>Female</th>
<th>Male</th>
<th>Average Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completers</td>
<td>5</td>
<td>1</td>
<td>43</td>
</tr>
<tr>
<td>Partial adherers</td>
<td>3</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td>Post-introduction decliners</td>
<td>2</td>
<td>1</td>
<td>51</td>
</tr>
<tr>
<td>Pre-introduction decliners</td>
<td>1</td>
<td>1</td>
<td>81</td>
</tr>
</tbody>
</table>

Figure 5: Individual patterns of attendance and change, by adherence group

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>First MOT</th>
<th>Activity changes</th>
<th>Diet changes</th>
<th>Exit MOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>Black</td>
<td>With others</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>39</td>
<td>Black</td>
<td>With others</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>40</td>
<td>White</td>
<td>Alone</td>
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3.2 Complete adherers

When reflecting on why they had attended FFS, completers made reference to specific motivations to look after their health that had existed prior to the launch of FFS. One completer talked about FFS as “kick starting” the new healthy lifestyle she had wanted for herself, another talked about it supporting an existing training programme for a 60K walk, and another talked
about her awareness of aging and the difference between her healthiness currently compared to when she was younger.

The completers reported positive experiences at the introductory MOT, with an overarching theme of the experts and the tests raising awareness. One interviewee explained that she had previously been unaware of the changes she had been making to her diet but that her conversation with the nutrition specialist had enabled her to be aware of the specific, subtle changes she had made. Another interviewee talked specifically about the nutrition specialist increasing her awareness of the role of nutrition during pregnancy. Even when the biological tests had indicated that her cholesterol was too high, one completer framed the testing in terms of the result providing her with the knowledge of the problem and subsequent happiness that it had not been higher. She felt that because of the testing she had been able to change and maintain her cholesterol through changes to her diet and increased physical activity.

The completers, by definition, are the only group to take up and participate in physical activities and classes throughout FFS. This group talked about the available activities as fitting in with their existing life, for example swimming as a suitable activity to do with the kids (rather than an activity that required and was made inconvenient by the need for childcare) and as enjoyable, for example how much fun salsa classes were and how much joy walking across Clapham Common can bring. Even though the scheme had finished by the time of the interviews, the respondents reported continuing with similar classes (for salsa), identical activities (regular swimming) and extensions of the original groups set up under FFS (a self-maintaining walking group).

Like most of the sample, the completers reporting making positive changes to their diet. In particular they identified receiving personalised advice about intake and diet modification (for example reducing nut consumption, changing from coffee to hot water and lemon in the morning), guidance about reading food labels and reducing salt intake, and specific directions about how to limit and change fat intakes.

Overall the completer group was characterised by having pre-existing interest and motivation in leading a healthy lifestyle, felt able to participate in activities that were convenient with their “normal” pre-scheme life style, received and remembered diet advice that had direct relevance to their everyday preparation and choice of foods, and demonstrated long term commitment to making healthy changes in their lives.

3.3 Partial adherers

The partial adherers reported specific health concerns as motivating factors for attending FFS, with an emphasis on the desire for or interest in the free
testing that was being offered. Two women reported being motivated to go to ensure that they had their husbands, as well as themselves, tested because of pre-existing concerns. The concerns were perhaps comparatively more serious than in the completers group: a perceived hereditary history of heart disease which had led to the death of a father in his 50s, self-reported obesity and being seriously overweight at 19 stone, and a recent set of tests that had identified a concern over an irregular heart beat.

When reflecting on the results from the tests carried out at the MOT, the partial adherers were fairly moderate in their responses; one woman’s weight was more than she “had hoped”, but it was also considered to be “absolutely fine”; another woman’s test results were overall higher than the normal range, but this was phlegmatically considered unsurprising as she already knew that she was “getting out of hand”. Although one man’s results were a little high the first time, the follow-up showed improvements and so were considered to be “nothing to worry about”; and another respondent explained that the results had helped her to “stop worrying”.

This group, by definition, did not participate in the physical activities and classes, but there was no consistent explanation as to why. One respondent felt that her exercise classes, twice a month, elsewhere were sufficient and did not need to be supplemented; another respondent felt that his job was so physically demanding that exercise was not a priority; another reported that she wanted to take up activities but that the classes were not run as advertised and that the course was over before it had started; another respondent explained that he had not been aware of the activities that were offered and had not considered an increase in physical activity as part of the FFS scheme.

The partial adherers reported that the information provided at the fist MOT was “basic” to “very informative”, and reported little detail about specific recommendations for physical activity. None reported having spent time with the exercise specialist, which may go some way to explaining the implicit contradiction between the comments above and the messages that were integrated within the FFS materials and introduction MOT sessions. Respondents in this group also made it explicitly clear than they had greater interest in and use of the practical information provided about diet and food changes.

Some of the strongest recommendations for FFS come from the partial adherers: one respondent felt that they were leading to “maybe a heart attack” and that the scheme had taught her important information about her diet and the food she was consuming. Another respondent felt that his commitment to the FFS scheme had led to a “lifestyle change rather than a diet” and was pleased with the gradual and sustainable changes to his weight and food and alcohol intake.
Overall the partial adherer group was characterised by stronger specific health concerns (rather than healthy interests) prior to FFS, a declared interest in the testing available, little interest or motivation to try the activity groups and overall positive responses to what they felt they had achieved from taking part.

3.4 Non-participants

The non-participants include a broader group of people who did not feel that the FFS scheme met their needs for various reasons.

Similar to the partial adherers, respondents who discontinued FFS (that is did not participate beyond attending the first MOT) were motivated to attend for quite weighty concerns about illness; one was concerned by her father's diabetes; another was concerned by the number of his friends dying of heart attacks and strokes. However, unlike the partial adherers the post-introductory decliners reported negative experiences at the first MOT. One respondent was disappointment with the equipment and exercise experience provided; another respondent was disappointed by the lack of expertise provided by the nutrition specialist. Again in contrast to the previous groups, those who discontinued with FFS indicated surprise at their results being increased above a healthy average with no attendant motivation to lower or maintain their measurements being reported.

The post-introductory decliners inferred that FFS did not “fit” with the rest of their life. One respondent explained that her commitments to her studying meant it was inconvenient to attend classes and that although the follow-up tests were made available; it was “me not making it” that stopped her from returning to the scheme. Another respondent outlined that his business took him away from the area, and that he had a very active lifestyle that did not fit with regular commitments. A female respondent echoed this point, that at the time she became too busy to commit to FFS and that the things that were offered as part of the scheme were not at times she could go. In addition she felt that “it all felt a bit sad” and that FFS was not “aimed at me” (see section 6 for further comment on this).

Those who declined to take part in FFS at all, the pre-introduction decliners, also reported a perception that the scheme was fine for others but was not aimed at people like them. This was in part due to the perception of it being unsuitable for older people and also that the scheme would not provide anything suitable for their physical needs (“occupational therapy would be more useful than physical education”) or their age group (“too old”, “at my age”). The provision of testing and advice through other health services, for example through annual check-ups with their GP, also gave the impression
that attending a scheme like FFS was "a waste of time", repeating tests that had already been carried out satisfactorily elsewhere.

Overall the post-introduction decliners reported a difference between their expectations of the scheme and their experiences of it, whilst the pre-introduction decliners reported a perceived gap between their health needs and their expectations of what could be provided by a community scheme. Post-introduction decliners identified being disappointed by the range of facilities for exercise within the MOT session, the lack of actual hands-on demonstrations of exercise (as opposed to advice or membership for ongoing classes), and indicated surprise that nurses were present at the MOT and testing would be carried out during the session (rather than at external appointments).

Perceptions of the threat of poor health were both motivators to go for the post-introduction decliners, and justifications for not bothering for the pre-introduction decliners. This group was, unsurprisingly, the most negative about the scheme, identifying its weaknesses and limitations of who it was aimed at and what it could provide.

3.5 Interviewees who left the study

During the course of the interviews, following informed consent procedures, the research team had to abandon two interviews and withdraw the interviewees from the study. Both of these terminated interviews were husbands of women who had encouraged them to take part in FFS, and subsequently to be interviewed as part of this analysis. However, participation in the interviews was presented as unwilling and coerced by their spouses and so, obviously has to be withdrawn. It is also of note that during the recruitment process the research team was faced with some hostility as it was felt by some participants that they had been hounded by FFS staff. One of the interviewees in this study makes reference to the "increasingly tetchy little people" who rang them, and it seems likely that some of the people who refused to take part in this study would have given less favourable accounts of the FFS staff than are represented here (see also comments in Method section).

3.6 Barriers to participation

Two broad themes emerged from the interviewees' reflections on functional barriers to their participation in FFS: where activities were held, and when they were held (see Figure 6). Activities and classes were considered inconvenient due to other life commitments such as work, study and childcare responsibilities outside of school hours. Locations were considered not
adequately accessible due to a lack of familiarity with the venue or due to perceptions of it being too far away.

**Figure 6: Barriers to participation**

### Work, study and children as barriers

The things that they offered weren't at times when I could go (C)

I don't get out much to the classes anymore because I'm doing studying, so all my time's really taken up in that (A)

The time was wrong... The hours at work makes it a bit difficult and in the evening I'm at home with the kids (F)

I got home too late from work at the time because I worked in central London, I think the classes were too early. (G)

I haven't gone to it since I've had her [new baby] (G)

If I wasn't working I know I would have attended almost all the classes but because of my work... we weren't able to because of my work (I)

Going to work, I sometimes finish late... the time was difficult for me to go [to other classes] maybe if the time was different then I would've gone (L)

### Distance and familiarity with the venue as barriers

I don't attend because of [the classes] being too far for me to go... they were quite far from where we live (B)

Agnes Riley Gardens isn't in the A-Z and on the website it doesn't actually say where it is so I didn't go because I couldn't find it (G)

The building wasn't labelled, it was kind of hard to find the building because they didn't actually give an address (K)

In addition to these functional barriers, there were social and experiential barriers, considered in the following sections: socio-demographic factors, support and potential improvements.

### 3.7 Socio-demographic factors

As in the quantitative study, patterns of participation were not drawn along ethnic lines and there was no declaration or inference that decisions to
participate or not participate were directed by ethnic or cultural considerations. The cultural imperative voiced in the interviews was that of a need to be 'healthy' and the shared, if ambiguous, goal of being 'healthier', which was equally held in both the ethnic groups used here. Age, gender and perceptions of healthiness were more likely than ethnicity to be used as terms of reference when describing or justifying patterns of participation in FFS (see Figure 7).

Age in particular was used to explain both complete adherence to FFS, because things start to affect your health more as you get older, and also for complete non-participation, because you can also get "too old" for such schemes. As noted in the quantitative report, older and elderly people were not recruited into FFS in large numbers, but in this sample there was a perception that many other FFS users were older and that this had a negative effect on the experience of younger users; either excluding them from popular activities or contributing to a boring social setting.

It is interesting to note that the average age of the sample interviewed for this evaluation was older than the average age of participants at the outset of FFS, and for women was older across all phases of FFS (see Figures 1 and 3). It would appear that perceptions of the age at which you can be considered 'old' or 'elderly' vary considerably. This notion of age is self-referent and somewhat age dependent.

The role of gender, and particularly of masculinity and men's indifference to looking after their health, was referred to by some interviewees in a joking, light tone. However, in parallel to this was an inference that male participation may be seen as unmanly; one male completer felt that he should explain that he had not been 'feminine' in joining FFS, and another interviewee interpreted healthy-looking men present at FFS as homosexual.

Figure 7: Social descriptions of participation and healthiness

<table>
<thead>
<tr>
<th>A shared imperative for healthiness</th>
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<tbody>
<tr>
<td>Basically we went for our health... I feel healthier. (A)</td>
</tr>
<tr>
<td>I basically wanted to get fitter and you know, how to choose the right foods to eat. (E)</td>
</tr>
<tr>
<td>I want to get back on a healthy track (G)</td>
</tr>
<tr>
<td>Just really to get my own idea of my own health (K)</td>
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</table>

<table>
<thead>
<tr>
<th>Age of other participants in FFS activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>[other participants were] mostly elderly, not much young people (A)</td>
</tr>
</tbody>
</table>
[the class] was fine but just a lot of old people. There wasn't enough young people [I thought] I'd get a lot more people, young people, I could chat with and network, but no, and I got bored quickly. (F)

ey said that [particular dancing] classes were for people who were over 50, I think, the pensioners, but as the time goes on they started opening it up for other, younger people as well (I)

Age and the suitability of FFS for improving one's health

At my age, I didn't think [FFS] was much good to me (D)

I am too old for this sort of thing (P)

I didn't go there to lose weight, because I know I'm older, you tend to put weight on, as you get older, these things affect you (I)

Gender

Mostly men just keep on drinking and we don't go to our GP... don't have time to check our health. And I'm one of them, you know, I am definitely one of them. (H)

I actually took my husband with me. It was a joint decision, but I probably persuaded him to come more because I wanted him to get checked out... because I was worried about my husband as well... You know what men are like. (J)

It would have been nice to have had more men around... it wasn't feminine but it was... more women than men. (O)

The people that I saw strolling in and out, I'd noticed you know that there was a couple of gay guys and I thought "this is not picking up the sort of people who were asked" (C)

3.8 Social identity and 'not like me'

For non participants (pre- and post- introduction decliners), there emerges a theme of FFS being for people 'not like me', positioning oneself as socially distant from the scheme the people it was perceived to be aimed at or suitable for. This social distance was conceptualised in terms of age, physical ability, lifestyle capacity to commit to an organised scheme and perceptions of social-economic status or class (see Figure 8).
Whilst it may be countered that nominally there was ‘something for everyone’ and that FFS was open to the whole community, these interviewees articulate perceptions that FFS was not compatible with their pre-existing lifestyle or health needs. For them, they were too old, too disabled, too busy or not who was intended for the project, to see themselves as part of the scope of FFS.

**Figure 8: Social identity and declining FFS**

And a healthy person I, I do a fairly healthy routine anyway, so I was just checking out what’s available and the things that were weren’t of interest to me. All of those [things I already do for my health] I do because I don’t have to fit them into anybody else’s routine.

It [FFS] was just, it wasn’t kind of cool (laughs). It all felt a bit sad and I thought I’m going to go, if I go to any of these this is not going to make me feel happier.

It didn’t feel like it was, I wasn’t being aimed, it wasn’t aimed at me, it was aimed at (sighs) the area which is very mixed and people who don’t have a healthy regime. Well, because I was sort of talking to people and trying to find out who they were trying to get from the catchment area and what the aim of it was, and I, I was kind of curious about how Flora was involved and you know, the whole thing, so I suppose, it just felt like there was a huge gap between the sorts of people who do take care of themselves and the sorts of people who don’t, and it felt like a class gap. Not, which isn’t obviously to say that everybody who’s of one class takes care of themselves and everybody who doesn’t, you know, but it felt like a, a wealth/poverty gap and all of that. (C)

Fine for different people, but at my age I didn’t think it was, it, well, much good to me in other words. It’s for people’s health, good luck to ‘em’s what I say.

If I find it necessary, if I get to a position or a state where I can’t help myself then I’ll ask for help. But not until then, I don’t think it’s [necessary]. (D)

I couldn’t get to [FFS] at that time, because of my schedule... because I’m doing studying, I got the appointments was fine, it’s just me not making it. (A)

To be very honest, that particular time I was away, on a business trip and I came back [and I missed the next session] but I always keep saying that I’ll probably catch you again. (H)

I have disabilities, difficulties moving and hearing. I couldn’t go along and just join in. I couldn’t have got to it [the venues]. The sort of help I need for my health is through the Occupational Therapist... the physiotherapist... I don’t have the same health problems that other people round here do. (P)
3.9 Sustaining changes in diet and activity

Of all the interviewees who reported making some changes to their lifestyle after attending FFS (i.e. excluding the pre- and post- introduction decliners), only two people indicated that the changes they had made were unsustained (see Figure 9). For one interviewee, her life had changed dramatically since the scheme started and the arrival of a new child had hampered her healthier changes. For another interviewee, the end of FFS had meant that access to her preferred type of exercise was no longer financially sustainable, though she had maintained some of the changes to her diet. Both interviewees hoped that they would resume physical activity again in the future.

The remaining participants, both partial adherers and completers, reported feeling that they had been able to integrate the changes suggested through FFS, and that they were realistically sustainable, particularly in terms of maintaining dietary changes.

**Figure 9 : Sustaining change after FFS**

**Changes that had not been sustained**

I mean, I'm planning to go to the gym. Now, there's one down in Streatham and they got a crèche and it's nearly 60 pounds a month, just so that I can use a crèche, you see, so you know I mean, I can't. (E)

I haven't been [exercising] recently because I've got [the baby] now, but I would like to start eventually when I can get a baby sitter or something... I ate very healthily when I was pregnant, but I don't know, I don't really eat much, just eat what you can at the moment [laughter], so I'm not, I think it's just because of her, really. (G)

**Sustainable changes**

Yes, I'm keeping up [the diet changes], yes and eat more of vegetables... Even though the Floras, all the classes have come to an end, other people have taken over the [dancing] class now, and I still attend it. (I)

I mean I did change my diet more so my activity, from what the information they'd given me on my diet. My weight was down slightly from the previous [MOT session]. It was down about six pounds actually, so I was quite pleased. I've been losing weight very, very gradually and it's stayed sort of down because I've made it like a lifestyle change rather than a diet, so I kind of don't have sugar in tea and I don't drink alcohol as I say, hardly at all. And I'm watching the salt levels. (M)
3.10 Agency and structure

In the themes discussed so far (levels and patterns of adherence, barriers to and social descriptions of participation, and the role of social identity) it is possible to identify both agency and structure in the narratives of attendance and non-attendance. In part this reflects a strength of the FFS scheme design: to increase agency through the provision of advice, feedback and practical information and also to provide structure in Clapham Park for healthier living though classes and alternative and affordable routes to participating in activities and testing.

However, in the context of FFS it is not possible to delineate the two satisfactorily. The mere presence of a healthy living initiative dedicated to Clapham Park in itself increases the structural support, by broadening the range of "what there is to choose from". For those interviewees who participated in at least the initial MOT session (excluding pre-introduction decliners), there is at least some degree of agency raising through the knowledge and awareness of one's own health, generated through the physiological tests and immediate feedback about the test results. For some participants this emerges as an overt increase in the ability to make healthier food choices, though education and directive activity and diet advice. For other participants this emerges less directly, may perhaps be characterised as 'empowering' the participants by raising their health self-knowledge or perhaps characterised as reassuring them that the choices they had already been making were having positive influences on their current healthiness.

While FFS increased the capacity for healthy living throughout the community in Clapham Park, individually this may not have been perceived as providing accessible or available structures due to functional barriers of participation. Similarly, FFS may not have been perceived to have provided structures or opportunities that were preferable to what was already available. Arguably, FFS may have increased both individual agency (awareness, knowledge, decision making capability) and community structures (classes, activities and healthy priorities in locality) without the individual actually deciding to adhere to the scheme.

The key theme here is that of choice and not direction. This increase in choice both as the actual functional provision of opportunities and also as awareness and the attendant individual preferences, is considered in the next section as a hybrid of agency and structure: the emerging role of support.
3.11 Support

The theme of support was reflected in range of topics during the interviews (See Figure 10). Support was referred to in terms of being encouraging and motivating people to adhere to the scheme, acting as a facilitator to participation. Support was referred to as a service in itself, alongside the activities and information participants were pleased to have the support of professionals. Support was also conceptualised as being the positive experience when participating; the supportive way in which people were handled and spoken to was a part of the overall perceptions of the scheme appropriate and something that people wanted to be a part of.

However, a concurrent theme also emerged here, that of inferred dependence on the scheme and reliance on the support provided by the intervention to sustain healthy living changes. Some participants reflected that the best improvement that could be made to FFS was to bring it back, or extend it for longer (see Figure 11, and also section 3.12 for other suggestions for improvements). For these participants, the value of the short term intervention is not assured after the end of the scheme. Even where they feel that some of the dietary and activity changes are sustainable (see section 3.9), there is no reference to finding a sustainable, equivalent source of support outside of FFS.

Figure 10: The role of support in participating and benefiting from FFS

<table>
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<tr>
<th>Completers</th>
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<tr>
<td>I think it needed to have a blitz of it often, like once a year or something so everybody can just continue because there are lots of people that want their kick start like me and they don’t have anything like that to actually get them and this helped me to do that. ... It would move people to pick up and do something, at least go and start. (F)</td>
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<tr>
<td>It was nice to have sort of a regular check-up session, just somewhere you could drop in... It was just sort of checking your progress and also they were quite encouraging so you felt, it was just quite good to have a bit of feedback about how you’re doing and if you’d for any reason sort of slacked and when it came round they’d say, right we’re gonna check up on you, you’d just think, oh let’s start again, sort of thing, so it’s quite sort of motivating. (G)</td>
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<tr>
<td>There was a place where there were people, nutritionists... I was interested to go and meet them. Sometimes I had a million things to do and then [FFS staff] were reminding us to attend. (I)</td>
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<td>Whatever question I asked or whatever ... somebody’s always there to answer. (L)</td>
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</table>
Partial adherers

They were very excellent ... they didn’t really make me feel, you know, “oh, you know you are over obese”, you know they encouraged me. If we even pay a surcharge, you know, I wouldn’t mind, because you know, you get the support from the team that you know were there at the time. I would love to have something like [FFS], come back in, for the motivation. (E)

I think [FFS] is very much needed because without it my husband wouldn’t, he never goes to the doctors. (J)

And just being told by, you know, someone like a doctor, having a bit of advice so then you could change ... it was very satisfying. (M)

Figure 11: Preferences for maintaining FFS in the community

I was really disappointed when basically it came to an end, because I thought it was something that would, you know, I didn’t realise that it was for a year, I thought it was something that was ongoing, because we do need something like this. The only thing that I would like to know that, you know what I mean, that they could have bring back the programme. (E)

I wish it would come again. (F)
I wish it would come back (G)

3.12 Suggested improvements for similar schemes

Interviewees were directly asked to comment on what changes they would like to see, if FFS or a similar project returned to the area. Understandably, answers were strongly reflective of the previous sections (see Figure 12).

There were functional recommendations, nominating more local venue locations, broader range of class times and increased availability of childcare facilities as areas for improvement. The time of day exacerbated problems that some interviewees had with travelling to activities; irrespective of other commitments there were safety considerations for travelling later in the day.
Additionally, a need for more specialised dietary information was identified. Some interviewees felt that the nutrition advice offered was not much more than common sense, and needed to be more in depth.

One suggestion was for more specialised dietary tests, such as food allergy testing, to support individualised dietary advice. Another suggestion was that diet advice needed to be framed with greater understanding of people’s addictions to foods, such as chocolate, and how to include those in diet plans, and what were ‘safe’ or ‘maximum’ amounts people could eat of their favourite ‘bad’ foods. Another interviewee indicated that scientific explanations about the function of foods and ingredients was important; for example not just that sugar should be reduced, but *why* it should be and what connection there was between sugar intake and ill health, in comparison for example to the known effects of salt intake and hypertension.

Finally, there was some indication that the scheme would ‘reach out’ to more people through better and sustained promotion, and greater use of financial incentives, such as discounts, vouchers and ‘freebies’.

**Figure 12: Improvements for healthy living initiatives**

<table>
<thead>
<tr>
<th><strong>Functional changes for classes and activities</strong></th>
</tr>
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<tbody>
<tr>
<td>Put them on in more areas... more local to where people live (A)</td>
</tr>
<tr>
<td>Late in the evening, it’s too dangerous for me to go out on and come [back] on my own (B)</td>
</tr>
<tr>
<td>With crèche facilities (F)</td>
</tr>
<tr>
<td>A few more different times for classes (G)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Improving information and specialising advice for participants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The nutrition advice was quite basic... maybe allergy testing, you know for food allergies and things like that (J)</td>
</tr>
<tr>
<td>If you’re addicted to chocolates or fruits and stuff like that, how much can you eat of that particular thing before you, you have to stop (A)</td>
</tr>
<tr>
<td>To be very honest, I don’t know the real effect of sugar. Salt I know that it narrows your arteries and you know causes much, you know, some of this hypertension and it’s been a long time indeed, even before I was born, salt is no good, you know. But, concerning sugar, I don’t know the fact of it. If I knew then I’d probably stop taking it [laughing] like, like smoking, they say smoking kills... I haven’t done it for a long time, I’m not a smoker these days. (H)</td>
</tr>
</tbody>
</table>
Promotions and discounts

They need to advertise it more... promoted more... drop leaflets through people’s doors, maybe in the local papers... and more offers, like more discounts (A)

more freebies, like vouchers... if I have a voucher to go to the gym I will definitely end up going (F)
CONCLUSIONS

Across the sample of interviews discussed here not everybody who had heard about FFS identified with the scope and potential benefits of a community based healthy living initiative; not everybody expected the same features, services and time span of FFS; and not everybody who went to FFS wanted to achieve the same goals. However, several themes emerged from the interviews, characterising levels of adherence to the FFS, barriers to participation and facilitators to adherence.

4.1 Characteristics of groups defined by level of adherence to FFS

The three levels of adherence identified through the interviewees descriptions of their uptake of testing, diet advice and activities demonstrated different patterns of motivation, reactions to testing, engaging in and maintaining healthy changes and overall evaluation of the scheme.

Completers (F, G, K, L, O)
- Motivated to look after and increase their health
- Some suggestion of making changes towards a healthy lifestyle prior to FFS
- Positive reaction to the test results at the initial MOT
- Positive response to follow up test results
- Engaged in FFS activities, which were convenient
- Made changes to diet
- Self reported sustained changes to diet and exercise
- Strongly valued the ‘support’ provided by FFS

Partial Adherers (B, E, J, M, N)
- Motivated to attend by specific, serious health concerns
- Some suggestion of information seeking prior to FFS
- Not concerned by test results at initial MOT
- Self reported sustained changes to diet
- Did not make sustained increase in physical activities
- Broad satisfaction with outcomes of own participation, but also identified areas of incompatibility between what was offered and what was ideal for them

Non-participants (A, C, D, H, P)
- Motivated to attend without clear goals to achieve through FFS, or motivated to not attend because of an apparent gap between what was offered and what was needed
• Disappointment with test results at initial MOT (if attended), framed in terms of dissatisfaction or uncertainty about the credibility of the results
• Did not incorporate health advice into daily lifestyle; or did not ask for advice
• Broad ambivalence about the scheme

4.2 Barriers to attendance

Interviewees identified functional and social barriers to attendance. Functional barriers were centred around the convenience of activities, the scheduled times of organised activities and distance between organised activities and home. Commitments to physical exercise and activities had to be compatible with existing work, studying and child care responsibilities. Some interviewees reported having exercise classes or routines in place prior to FFS, and these acted as additional commitments for FFS to work around and also as a reason for not needing, or not having time for, further physical activity.

Lack of local knowledge about the locations of venues, and perceptions of the lack of safety using public transport or walking alone to venues also acted as functional barriers to attending MOTs and classes. Physical disability prohibited one interviewee from attending FFS, both in terms of ability to travel to and attend sessions, and also in terms of participating in non-disability specialised activities.

The interviewees’ own interpretations of who FFS was for and what it could do for you acted as social barriers. The apparent lack of basic health awareness, in terms of perceptions of other users and as reflected in the advice and information received from the experts, discouraged some interviewees from pursuing FFS or associating their own health needs with what might be achievable through FFS.

Age was seen as a reason to attend FFS and also as a reason for not attending. There were quite pronounced opinions that FFS was unsuitable for older people, and also that the scheme would have benefited from having more younger people involved, as older aged groups discouraged some from continuing attending classes.

For some interviewees, community schemes like FFS were seen as ideal for men who would otherwise not have contact with health care professionals or have ‘check-ups’ for their health. Wives, girl friends and boy friends were reported as accompanying men to FFS sessions, but there was also some comment that they had been ‘persuaded’ into attending, and that left to their
own devices FFS would not appeal to the average, heterosexual man who is disinterested in his own health.

4.3 Facilitators to adherence

Across the sample one point of agreement was the need individually and communally to improve and protect health. The framing of FFS as a healthy living initiative, to assist in generating improved health in Clapham Park was essentially applauded, even though some non-participants identified themselves as different from those that ‘need’ help, it was seen as having a positive effect for the community.

The provision of free physiological testing and advice was seen as desirable and was a motivating factor for all of those in the sample who attended FFS at least once. Although some interviewees were surprised, and some disappointed, by their results, no one reported feeling uncomfortable being tested, or being discouraged from attending by the prospect of taking part in the tests. One to one information and feedback facilitated attendance, as a ‘selling point’, and once at FFS it also provided context and direction for involvement in improving one’s own health.

The role of support emerged as a key factor in facilitating attendance and adherence to a healthier lifestyle, through encouraging and motivating people to initiate and maintain healthy changes, as well as being a positive outcome for the individual to feel supported during their participation.

4.4 The roles of diet and exercise

Participants were more likely to report making changes to their dietary intake, and sustaining changes to their diet than to report increasing their physical activity levels, and this difference directed the first level of analysis of the interviewees’ patterns of adherence to FFS.

In the context of other emerging themes, it appears that for this sample making changes to the diet was preferable, easier, more affordable and more convenient than increasing exercise. Changes to the diet do not necessarily demand more time, or greater regular commitments than already exist in their daily lives: they are already eating food, at times to suit their schedule and their tastes.

Exercise potentially requires greater allocation of time, more travelling and in many cases a new commitment to take on. The connection between increased knowledge and gaining benefit from what you know is less direct in exercise than in diet; it is possible to take diet advice home and follow it,
whereas with exercise advise you have to take it home and convert it into exertion and changed routines.

It is perhaps not surprising that the information and testing were the most popular parts of FFS, but they were also criticised for being too basic and the content being insufficient to go beyond what people already knew. On the other hand, participants who maintained physical activity were wholly positive about the content of the exercise opportunities provided by FFS; the criticism came for withdrawn classes and facilities, inconvenient times of classes and the lack of interest from other participants.
RECOMMENDATIONS

The following recommendations are based on the suggestions and experiences of the interviewees, for future healthy living community initiatives.

1. Make it clear that the intervention is only intended to last a limited time

2. Make efforts to ensure access for those with physical disabilities and promote the availability of accessible locations and spaces. Consider the role of physical disabilities and limitation when designing activity programmes for communities

3. Try to include affordable and financially sustainable activities that can remain after the end of the scheme; or where that is not possible, ensure that exit sessions help participants to identify replacement affordable activities

4. Try to develop socially encouraging groups and support for participants, or engage in activities that are community led, so that the support is not withdrawn at the end of the schemes; or where that is not possible, ensure that exit sessions help participants to identify replacement support and sources of encouragement and inspiration

5. Deliver person-specific information and advice, and offer the opportunity for participants to ask their own questions about their healthier lifestyle choices. At the end of the scheme ensure that participants have identified alternative sources of health advice and information

6. Dietary changes need to be supported by specialised information, and clear directions for a range of dietary requirements

7. Exercise changes need to be supported by regular, accessible locations and times for classes, appreciating the role of motivation to ‘keep going’ and the role other commitments play in deciding whether or not it is personally feasible to exercise

8. Schemes need to be sensitive to the environment in which they operate, including local knowledge of the area, and times and routes which are considered ‘safe’ to use when travelling between home and venues
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